

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 46

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Fort Howard, Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 months  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County   
 City or town Fort Howard  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 19 North Point Road  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Laura L. Alwater

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White widowed

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 14, 1882

8. AGE: 66 10 15  hrs.  min.  
 Years Months Days If less than one day

9. Birthplace Baltimore - Md  
(Town, county, and state)10. Usual occupation none

11. Industry or business

12. Name John S. Keyser, Jr.13. Birthplace Baltimore - Md14. Maiden name Barkera Derrington15. Birthplace Baltimore - Md16. Informant Mrs. Hazel ColbertAddress 19 North Point Road17. Burial Date thereof 12/31/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Moreland Memorial ParkLocation Taylor Ave18. Funeral director Howard N. Bright, Jr.Address 6009 Bayford Road19. Dec 30 48 A. W. Hedrick  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 29, 48 at 10 PM

21. I CERTIFY that death occurred on the date above stated that I attended deceased from  
December 1, 48 to Dec 29, 48  
 and that I last saw her alive on December 28, 48

Immediate cause of death Chronic congestive heart failure DURATION 5 yrs.

Due to Arterio-sclerotic heart disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. W. Hedrick, M.D.Address 520 D St. S.P. 9 Date signed 12-30-48

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

12149

Reg. Dist. No. *4x*

### 1. PLACE OF DEATH:

County Baltimore

City or town Essex  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore

City or town Essex  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 7529 Eastern Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

Jennie Baker

### 3. (b) Social Security Number

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife Harry Baker

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 22, 1881

8. AGE: Years 67 Months 11 Days 5 It less than one day hrs. min.

9. Birthplace Baltimore  
(Town, county, and state)

10. Usual occupation at home

### 11. Industry or business

12. Name Henry Nagle

13. Birthplace Baltimore

14. Maiden name Louise McCroy

15. Birthplace Baltimore

16. Informant Harry Baker

Address 7529 Eastern Ave

17. Burial Date thereof 12/30/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Oak Lawn

Location 7225 Eastern Ave.

18. Funeral director Clarence F. Hoffmann

Address 1639 N. Broadway.

19. Dec 30 19 48 Q. W. Hedrick  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 27 19 48 at 3:00 P

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Dec 15 19 48 to Dec 27 19 48  
and that I last saw her alive on Dec 27 19 48

Immediate cause of death Chi. Lymphatic Leucemia

### DURATION

1-18-48  
1-18-48

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? Home  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. A. Schenck M.D.

Address 8421 East Ave Date signed 12-28-48

MARGIN RESERVED FOR BINDING

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VS A15 9.45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 39

### 1. PLACE OF DEATH:

County Baltimore  
City or town RURAL -- Towson  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? ..  
Hospital, institution, or street address where death occurred:  
none  
How long in hospital or institution? ..

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Baltimore  
City or town RURAL -- Towson  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Jarrettsville Road near Loch Raven  
(If rural, give LOCATION)  
2.(a) If veteran, name war ..

### 3. (a) FULL NAME

William G. Baker, Jr.

### 3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Mary Drake Sawyers  
6.(c) If alive, give age .. years

7. Birth date of deceased (mo., day, yr.) December 21, 1874

8. AGE: Years 74 Months --- Days 6 If less than one day .. hrs. .. min.

9. Birthplace Frederick County, Maryland  
(Town, county, and state)

10. Usual occupation Banker -- retired

11. Industry or business ..

FATHER 12. Name William G. Baker

13. Birthplace Buckeystown, Maryland

MOTHER 14. Maiden name Susan Ellen Jones

15. Birthplace Montgomery County, Maryland

16. Informant Mrs. Joseph Baker

Address Monkton, Maryland

17. Burial Date thereof 12/30/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery Mount Olivet

Location Frederick, Maryland

18. Funeral director John C. Mitchell & Sons, Inc.

Address 1900 Eutaw Place, Baltimore, Md.

19. Dec 30 19 48 W. Carroll Van Horn  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH December 27, 1948 at 10:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1941 19 .. to Dec 27 19 ..  
and that I last saw him/her alive on Dec 27 19 ..

Immediate cause of death apoplexy  
chronic thrombosis

Due to arterio-sclerosis  
& hypertension

Other conditions ..

(Include pregnancy within 3 months of death)

Major findings of operations ..

Date of op. ..

Autopsy results ..

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide .. Date of ..

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John C. Mitchell & Sons, Inc.  
M. D. or other

Address 28 Allegheny Ave., Towson signed 12/28/48  
Md.

MARGIN RESERVED FOR BINDING

VS A15 9-4-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No.

### 1. PLACE OF DEATH:

County Baltimore  
City or town Catonsville 28, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 1 yr. 1 mo. 11 das.  
Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
How long in hospital or institution? 1 yr. 1 mo. 11 das.

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County   
City or town 800 N. Port Street, Baltimore, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.   
(If rural, give LOCATION)  
2(a) If veteran, name war

### 3. (a) FULL NAME

Anton Belsky

### 3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced divorced

6. (b) Name of husband or wife Anna Belsky  
6. (c) If alive, give age  years

7. Birth date of deceased (mo., day, yr.) May 24, 1885  
8. AGE: Years 63 Months 7 Days 7 If less than one day  hrs.  min.

9. Birthplace New York  
(Town, county, and state)

10. Usual occupation Plumbing helper

11. Industry or business Plumber

12. Name Tony Belsky

13. Birthplace Czechoslovakia

14. Maiden name Anna ----- Mellichor

15. Birthplace Czechoslovakia

16. Informant Hospital Records  
Address Catonsville 28, Maryland

17. Burial  Date thereof 12/4/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or place of burial Oak Hill  
Location Horner's Lane, Baltimore, Md.

18. Funeral director Schimunek Funeral Home, Inc.  
Address 2601-3-5 E. Madison St., Balto. Md.

19. Dec 2 48 A. W. Tuerk  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH December 1, 1948 at 11:55 am

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 20, 1947 to December 1, 1948 and that I last saw him alive on December 1, 1948

Immediate cause of death Terminal pneumonia  
Amputation of 3 toes of left foot  
for gangrene 3 months  
Midhigh amputation of left leg 2 months  
Due to Arteriosclerotic cardiovascular renal disease indefinite  
Other conditions Right indirect inguinal hernia  
(Include pregnancy within 3 months of death)

Major findings of operations Amputations for gangrene  
as above (9-7-48 and Date of op. 10-29-48)

Autopsy results none  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide  Date of   
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE Isadore Tuerk, M. D.  
M. D. or other   
Address Catonsville 28, Md. Date signed 12/1/48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 75-30

## 1. PLACE OF DEATH:

County BaltimoreCity or town Catonville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BaltimoreCity or town Catonville  
(If outside city or town limits, write RURAL and give nearest town)Street No. 519 Academy Rd.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Nellie Amanda Black

## 3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Alexander W. Black

7. Birth date of

deceased (mo., day, yr.)

March 16, 1887

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

61913

hrs.

min.

9. Birthplace

Pennsylvania  
(Town, county, and state)

10. Usual occupation

housewife

11. Industry or business

FATHER  
MOTHER

12. Name

Charles H. Boetz

13. Birthplace

Penn.

14. Maiden name

Catherine H. Pry

15. Birthplace

Penn.

16. Informant

Mr. Alexander Black

Address

519 Academy Rd

17.

(Burial, cremation, or removal. Which?)

Date thereof

Jan 1, 1949  
(month) (day) (year)

Cemetery or crematory

London Park

Location

Baltimore

18. Funeral director

George A. Finley

Address

Fulton Ave & Fayette St.

19.

12-30  
(Date rec'd by registrar)19 48T.E. Harry

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 29 19 48 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

June 21 19 48 to December 29 19 48  
end that I last saw her alive on December 28 19 48

Immediate cause of death

Atherosclerotic heart disease

DURATION

5 mo.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

William B. Gallagher, M.D.

M. D. or other

Address

Catonville 28, Md.Date signed 12/30/48

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1948

MARGIN RESERVED FOR BINDING

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age, especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

12153

Reg. Dist. No. 37

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Bessey  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 50 yrs.  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Baltimore  
 City or town Bessey  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

William Edward Blizzard

## 3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Sarah J. (Thompson) nee  
 6. (c) If alive, give age 52 years  
 7. Birth date of deceased (mo., day, yr.) Oct. 12 1870  
 8. AGE: Years 78 Months 1 Days 17 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Balto. Co. Md.  
 (Town, county, and state)  
 10. Usual occupation Crossing Watchman  
 11. Industry or business Perma. R.R.  
 12. Name John Blizzard  
 13. Birthplace Balto Co. Md.  
 14. Maiden name Carey Kemp  
 15. Birthplace Balto Co. Md.  
 16. Informant Mrs. W. E. Blizzard  
 Address Bessey, Md.  
 17. Burial Date thereof 12-8-48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Mt. Gillego  
 Location Woodlawn Baltimore Md.  
 18. Funeral director Sander M. Bissell  
 Address Sparks Md.  
 19. 12-7- 48 Wilmer C. Ensor  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 5 1948 at 6:40 AM  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1945 to December 1948  
 and that I last saw him alive on December 2 1948

Immediate cause of death Carcinoma - prostate  
 DURATION \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Elizabeth B. Stanfill, M.D.  
 M. D. or other \_\_\_\_\_  
 Address Cockeysville, Md. Date signed 12-5-48

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DEC 9 1948  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

12154

Reg. Dist. No. 44

### 1. PLACE OF DEATH:

County Baltimore  
City or town Fort Howard, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 1 day  
Hospital, institution, or street address where death occurred:  
Vets. Adm. Hospital, Fort Howard, Md.  
How long in hospital or institution? 1 day

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County \_\_\_\_\_  
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 2309 Greenmount Ave.  
(If rural, give LOCATION)  
2. (a) If veteran, name war WW I ☒

### 3. (a) FULL NAME

HENRY B. BOHN

### 3. (b) Social Security Number

unknown

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
6. (b) Name of husband or wife Julia Bohn  
6. (c) If alive, give age 43 years  
7. Birth date of deceased (mo., day, yr.) October 16, 1895  
8. AGE: Years 53 Months 1 Days 22 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

### MEDICAL CERTIFICATION

20. DATE OF DEATH December 8, 1948 at 8:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 7, 1948 to December 8, 1948 and that I last saw him alive on December 8, 1948

Immediate cause of death Coronary Thrombosis DURATION 8 Days

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Coronary Arteriosclerosis Unknown

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results none performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE JPD R.E. McDONALD, M.D. M. D. or other \_\_\_\_\_

Address VAH. FORT HOWARD, MD. Date signed 12-9-48

8. Birthplace New Haven, Conn.  
(Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business \_\_\_\_\_

12. Name Victor Bohn

13. Birthplace Germany

14. Maiden name Anna Schwartz

15. Birthplace Germany

18. Informant Clinical Records, Vets. Adm. Hosp.

Address Fort Howard, Maryland

17. Burial Date thereof Dec 11, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Baltimore National Cemetery

Location Baltimore, Maryland

18. Funeral director Wiedefeld & Son

Address Greenmount & 22nd Sts., Balto., Md.

19. Dec 10 19 48 aw Registrar

MARGIN RESERVED FOR BINDING

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

F

5. Color or race

W

6. (b) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Edward J. Bradley

7. Birth date of

deceased (mo., day, yr.)

Mar 22 1878

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

78

8

16

hrs.

min.

8. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

None

11. Industry or business

FATHER  
MOTHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, which)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

1948

V.E. Harag

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec. 8

1948

at 10<sup>20</sup> P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1

1948

to Dec 8

1948

and that I last saw him

alive on

Dec 8

1948

Immediate cause of death

Myocardial insufficiency

DURATION

1 day

Due to

Cardio-renal vascular

4 yrs

Due to

Disease

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

J.W. Wilson

M. D. on this

Address

617 W. 40th St

Date signed

12/8/48

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DEC 11 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

## 1. PLACE OF DEATH:

County BaltimoreCity or town Mount Wilson  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 0 yrs., 8 mos., 18 daysHospital, institution, or street address where death occurred: Mt. WilsonBranch, Md. T.B. SanatoriumHow long in hospital or institution? 0 yrs., 8 mos., 18 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town 407 S. Central Ave., Balto., Md.  
(If outside city or town limits, write RURAL and give nearest town)Street No. Baltimore, Maryland  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Elizabeth Bressi

## 3. (b) Social Security Number

218-16-0812

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 27, 1925

## 8. AGE:

Years

Months

Days

If less than one day

23016

hrs. min.

9. Birthplace Baltimore, Md.  
(Town, county, and state)10. Usual occupation Checker

## 11. Industry or business

FATHER  
MOTHER12. Name Achille Bressi13. Birthplace Italy14. Maiden name Lillian Difrencico15. Birthplace Italy16. Informant Elizabeth BressiAddress 407 S. Central Ave., Balto., Md.17. Burial Date thereof 12/16/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Holy Redeemer CemeteryLocation 4430 Belair Rd., Balto., Md.18. Funeral director Frank Della NoceAddress 322 S. High St., Balto., Md.19. Dec. 13, 1948 Helen R. Mayer  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 13, 1948 at 4:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 25, 1948 to Dec. 13, 1948 and that I last saw her alive on December 13, 1948

Immediate cause of death

Pulmonary Tuberculosis

DURATION

4 1/2 yrs.Due to Tubercle Bacilli

Due to

Other conditions Bronchial Pleural Fis- Unknown  
tula  
(Include pregnancy within 3 months of death)Major findings of operations No operation

Date of op.

Autopsy results No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

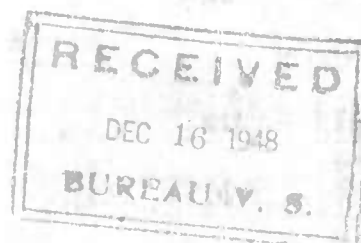
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Stewart S. Shaffer M.D. M.D. or otherAddress Mt. Wilson, Md. Date signed 12/13/48



FILM No. G 110 JAN 21 1949

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County Baltimore Co.City or town Woodstock, Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Woodstock College

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Balt.City or town Woodstock  
(If outside city or town limits, write RURAL and give nearest town)Street No. ....  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Rev. John A. S. Broome, Jr. S.J.

## 3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

S

6.(b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

October 21, 1860

6.(c) If alive, give age years

8. AGE:

88

Years

1

Months

18

Days

If less than one day

11

hrs.

30

min.

9. Birthplace

New York, N.Y.

(Town, county, and state)

10. Usual occupation

Priest

11. Industry or business

Religious - clergyman

12. Name

Not known

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Rev. Joseph B. Ruz, Jr.

Address

Woodstock College

17.

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Cemetery

Location

on grounds

18. Funeral director

Mr. B. H. B. C. Harle

Address

121 E. West St. 1946 Md

19.

Dec 10 1948

(Date rec'd by registrar)

19.

A. W. Nedrich

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 9 19 48 at 11:31 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 2 19 48 to Dec 9 19 48and that I last saw him alive on Dec 8 19 48

Immediate cause of death

Ischemic heart disease

DURATION

Due to

old age

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Harold H. Bevins

M. D. or other

Address 529 N. Charles StDate signed 12/10/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 48

## 1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard, Maryland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 23 days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp. Fort Howard, Md.How long in hospital or institution? 23 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore,  
(If outside city or town limits, write RURAL and give nearest town)Street No. 141 N. Exeter St.  
(If rural, give LOCATION)2.(a) If veteran, name war WW-1 ✓

## 3.(a) FULL NAME

ABBOTT BROWN

## 3.(b) Social Security Number

217-09-0536

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
<u>Male</u>	<u>Negro</u>	<u>Single</u>

6.(b) Name of husband or wife single

6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) December 25, 1883

8. AGE:	Years	Months	Days	If less than one day
	<u>64</u>	<u>11</u>	<u>13</u>	_____ hrs. _____ min.

9. Birthplace Petersburg, Virginia  
(Town, county, and state)10. Usual occupation laborer

11. Industry or business

12. Name John Brown13. Birthplace Virginia14. Maiden name Sarah Lewis15. Birthplace Virginia16. Informant Clinical Records, Vets. Adm. Hosp.Address Fort Howard, Md.17. Burial Date thereof 12-11-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Petersburg, Va.

Location

18. Funeral director Charles R. LawAddress 802 Madison Ave., Balto., Md.19. Dec 10 19 48 A. W. Helwick  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 8 19 48 at 7:00A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 15 19 48 to December 8 19 48and that I last saw him alive on December 8 19 48

Immediate cause of death	DURATION
<u>Rupture of Bladder</u>	<u>6 Days</u>
<u>Generalized Peritonitis</u>	<u>6 Days</u>
<u>Lower Nephron Nephrosis</u>	<u>6 Days</u>

Due to

Other conditions Hypertrophied Prostate 6 Mos.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results None Performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. E. McDonald M. D. or otherAddress VAH, FT. HOWARD, MD. Date signed 12-9-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 12159 XX

## 1. PLACE OF DEATH

County BaltimoreCity or town Essex Md  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. CountyCity or town Essex  
(If outside city or town limits, write RURAL and give nearest town)Street No. Back River Neck Road  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Eary Brown

## 3. (b) Social Security Number

4. Sex Female5. Color or race Colored6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Albert

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 11, 19098. AGE: Years 39 Months Days It less than one day hrs. min.9. Birthplace Eastern Shore Md.  
(Town, county, and state)10. Usual occupation Housewife

## 11. Industry or business

12. Name Albert Brown13. Birthplace Eastern Shore Md.14. Maiden name Elinor15. Birthplace Eastern Shore Md.16. Informant Margaret MilesAddress Back River Nk. Road17. Burial Date thereof Dec 31/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St Stephens CemLocation Essex Md18. Funeral director Mrs. Gott P. Elliott Dgt.Address 1429 N. Caroline St12/31/48 19 Max G Connelly Registrar

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26, 1948 at 10 P. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 26, 1948 to Dec. 26, 1948and that I last saw her alive on Dec. 26, 1948Immediate cause of death Cardiac Failure DURATION 1 weekDue to Broncho-pneumonia 3 weeksDue to Virus typeOther conditions Hypertension

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Maxwell H. Mund M. D. overAddress 417 1/2 Eastern Ave. Date signed 12-30-48

9091, 11153

**RECEIVED**

JAN 5 1949

**BUREAU V. S.**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 12160 44

## 1. PLACE OF DEATH:

County BaltimoreCity or town Edgemere  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

3111 Lynch Road

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Edgemere  
(If outside city or town limits, write RURAL and give nearest town)Street No. 3111 Lynch Road  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Elmer L. Bryan

## 3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

MaleWhiteMarried6.(b) Name of husband or wife Lorraine Bryan

7. Birth date of deceased (mo., day, yr.) 6.(c) If alive, give age years

Sept, 18, 19038. AGE: Years Months Days If less than one day  
45 2 26 hrs. min.9. Birthplace Baltimore  
(Town, county, and state)10. Usual occupation Bethlehem Ste. I Co.

11. Industry or business

12. Name George Bryan13. Birthplace Maryland14. Maiden name Sarah McJilton

15. Birthplace

16. Informant Mrs. Lorraine BryanAddress 3111 Lynch Road17. Burial Date thereof Dec 16/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory ParkwoodLocation Balto Co Md18. Funeral director Ullrich Funeral HomeAddress 2008 Orleans St19. 12-16-48 R. W. H. H. H.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 14, 1948 at 3:25 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 13 19 48 to Dec 14 19 48  
and that I last saw him alive on Dec 13 19 48Immediate cause of death Subarachnoid Hemorrhage DURATION 3 wks

Due to

Due to

Other conditions avulsion Rt hand 4 years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE G. W. H. H. H. M. D. or otherAddress Balto 6 Date signed 12-15-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

94 a

12161

Reg. Dist. No.

33-

## 1. PLACE OF DEATH:

County Balto.  
 City or town Parkton MD  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 10 yrs  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State MD County Balto  
 City or town Parkton MD  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

James Thomas Bull

## 3. (b) Social Security Number

4. Sex male 5. Color or race W 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Sybil Liding Bull  
 6.(c) If alive, give age 50 years  
 7. Birth date of deceased (mo., day, yr.) July 3 1891  
 8. AGE: Years 58 Months 5 Days 10 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Balto Co. MD  
 (Town, county, and state)  
 10. Usual occupation Father of family  
 11. Industry or business Black & Decker  
 12. Name Benjamin H. Bull  
 13. Birthplace Parkton MD  
 14. Maiden name Sarah J. Baker  
 15. Birthplace Balto Co. MD

16. Informant Mrs James T. Bull  
 Address Parkton MD  
 17. Burial Date thereof Dec 17 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Ever Pines Baptist Church  
Parkton MD  
 Location \_\_\_\_\_  
 18. Funeral director H. Seiple  
 Address Glen Park P.

19. Dec 16 1948 Charles J. Egan  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 13 19 48 at 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_  
 and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_

Immediate cause of death Heart on arrival  
Coronary occlusion

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_  
 Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Manner of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE A. M. France  
 Address Parkton MD Date signed 12/16/48

RECEIVED

DEC 28 1948

BUREAU V. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

12162

38

## 1. PLACE OF DEATH:

County... **Baltimore**City or town... **Bellona Ave. Mercy Villa**

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... **Md.**

County.....

City or town... **Baltimore**

(If outside city or town limits, write RURAL and give nearest town)

Street No. **2745 N. Calvert St.**

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3.(a) FULL NAME

**Bernadette C. Burch**

## 3.(b) Social Security Number

## 4. Sex

**Female**

## 5. Color or race

**white**

## 6.(a) Single, married, widowed, or divorced

**widow**

## 8.(b) Name of husband or wife

**Benj. W. Burch**

6.(c) If alive, give age..... years

## 7. Birth date of deceased (mo., day, yr.)

**Nov. 1, 1882**

## 8. AGE:

Years

**66**

Months

**1**

Days

**17**

If less than one day

.....hrs. ....min.

## 9. Birthplace

**Leonardtown, Md.**

(Town, county, and state)

## 10. Usual occupation

**none**

## 11. Industry or business

MOTHER FATHER

## 12. Name

**Br. Charles Coombs**

## 13. Birthplace

**Leonardtown, Md.**

## 14. Maiden name

**Rosa Hill Stone**

## 15. Birthplace

**Leonardtown, Md.**

## 16. Informant

**Benj. W. Burch Jr.**

## Address

**Wilmington, Del.**

## 17.

**Burial**

(Burial, cremation, or removal. Which?)

Date thereof **12/20/48**

(month) (day) (year)

## Cemetery or crematory

**New Cathedral**

## Location

**Balto. Md.**

## 18. Funeral director

**John O. Mitchell & Sons**

## Address

**1900 Eutaw Place**

## 19.

**Dec 20 19 48**

19 48

**A. W. Harris**

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH **Dec. 18, 19 48** at.....M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

**Jan. 2, 19 48** to **Dec. 18, 19 48**and that I last saw him alive on **Dec. 18, 19 48**

Immediate cause of death

**Cerebral hemorrhage  
Hypertension and  
arteriosclerosis**

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?.....

23. SIGNATURE

**John A. Trischer**

M. D. or other

Address **103 W. 39th. St.**Date signed **Dec. 19, 1948**



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

40

## 1. PLACE OF DEATH

County BaltimoreCity or town in Falmouth  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County BaltimoreCity or town in Falmouth  
(If outside city or town limits, write RURAL and give nearest town)Street No. R.F.D. Hyde  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Caleb C. Burton

## 3. (b) Social Security Number

4. Sex M 5. Color or race W. 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 22 - 18608. AGE: Years 88 Months 2 Days 17 If less than one day  
hrs. min.9. Birthplace Retired  
(Town, county and state)

10. Usual occupation

11. Industry or business

12. Name Owen B. Burton13. Birthplace md.14. Maiden name Louise Todd15. Birthplace md.16. Informant Mrs. Raymond BurtonAddress Hyde17. Burial Date thereof Dec. 11 - 48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Shaugh Chapel CemLocation Hyde18. Funeral director Clara E. ArthurAddress Farm19. Dec. 10 1948 C. E. Arthur

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 9 1948 at 2 P.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1 1948 to Dec. 9 1948and that I last saw him alive on Dec. 8 1948Immediate cause of death Pneumonia 5da.Due to Cerebral Thrombosis 9da.Due to Hypertensive Cardiovascular Disease

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

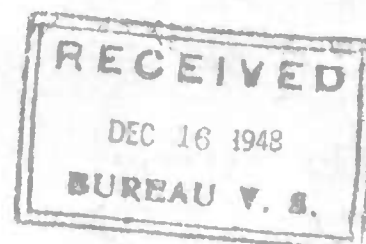
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, pub'c place (where?)

Means of injury Injured at work?

23. SIGNATURE Clifford F. Hudson, M.D.Address Farm Date signed 12/9/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Fort Howard  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 20 days  
 Hospital, institution, or street address where death occurred:  
V.A.H. Fort Howard, Md.  
 How long in hospital or institution? 20 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County \_\_\_\_\_  
 City or town Baltimore 17  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1211 Shields Place  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war WW I ✓

## 3. (a) FULL NAME

OTTO L. BURTON

## 3. (b) Social Security Number

Unknown

## 4. Sex

Male

## 5. Color or race

Colored

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Florence Burton

6. (c) If alive, give age 59 years

## 7. Birth date of

deceased (mo., day, yr.) March 5, 1895

## 8. AGE:

Years

Months

Days

If less than one day

5390

hrs.

min.

## 9. Birthplace

Baltimore, Maryland

(Town, county, and state)

## 10. Usual occupation

Unemployed

## 11. Industry or business

FATHER  
MOTHER12. Name Joseph Burton13. Birthplace Virginia14. Maiden name Sarah Jones15. Birthplace Virginia16. Informant Clinical Records, Vets. Adm. Hosp.Address Fort Howard, Maryland17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 12-10-48  
(month) (day) (year)Cemetery or crematory Baltimore National CemeteryLocation Baltimore, Maryland18. Funeral director Charles R. LawAddress 802 Madison Ave., Baltimore, Md.19. Dec 8 48  
(Date rec'd by registrar)A. W. Redlich  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 5, 1948 at 6:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
November 15, 1948 to December 5, 1948  
 and that I last saw him alive on December 5, 1948

## Immediate cause of death

DILATATION AND HYPERTROPHY RIGHT  
HEART WITH INSUFFICIENCY

## DURATION

18 hrs.

## Due to

PULMONARY EMPHYSEMA AND ASTHMA10 yrs.

## Due to

## Other conditions

(Include pregnancy within 8 months of death)

## Major findings of operations

Date of op.

Autopsy results Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

H.C. MANAUGH  
H.C. MANAUGH, M.D., CHIEF PROFESSIONAL SERVICESAddress VAH, FORT HOWARD, MD.Date signed 12-6-48

EVIDENCE FOR ADDITION  
IN # 21 SHOWN ON:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12165

FILE No. G 118 JAN 25 1949

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County... Baltimore,  
City or town... Fort Howard  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 4 days  
Hospital, institution, or street address where death occurred:  
Vets. Adm. Hospital, Ft. Howard, Md.  
How long in hospital or institution? 4 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State... Maryland County...  
City or town... Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 1205 N. Broadway  
(If rural, give LOCATION)  
2. (a) If veteran, name war... SAW

3. (a) FULL NAME

ROBERT L. BYRUM

3. (b) Social Security Number

Unknown

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widower  
6. (b) Name of husband or wife...  
6. (c) If alive, give age... years  
7. Birth date of deceased (mo., day, yr.) 3-13-72  
8. AGE: Years 76 Months 9 Days 17 Is less than one day  
hrs. min.

9. Birthplace Windsor, N.C.  
(Town, county, and state)  
10. Usual occupation Unknown  
11. Industry or business  
12. Name Jessie Byrum  
13. Birthplace North Carolina  
14. Maiden name Martha Pierce  
15. Birthplace North Carolina

16. Informant Clinical Records, Vets. Adm. Hosp.  
Address Fort Howard, Maryland  
17. Burial Date thereof 1/3/49  
(Burial, cremation, or removal, Which?) (month) (day) (year)  
Baltimore National Cemetery  
Cemetery or crematory...  
Baltimore, Maryland  
Location...  
18. Funeral director Howard Blight  
Address 6009 Harford Rd., Baltimore, Md.

19. January 3 1949 A. W. Paduch  
(To be rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 30, 19 48 at 10:10 P  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
December 27 19 48 to December 30 19 48  
and that I last saw him alive on December 30 19 48  
Immediate cause of death  
Purulent Bronchitis  
Pneumonia, broncho  
Due to E. 125/49 etc  
DURATION  
2 days  
2 days  
Due to...  
Due to...  
Other conditions None  
(Include pregnancy within 3 months of death)  
Major findings of operations... Date of op...  
Autopsy results Substantiated above  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide... Date of...  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?  
23. SIGNATURE Paul O. Anderson  
Paul Anderson, M.D. M. D. or other  
Address VAM. Fort Howard, Md. Date signed

MARGIN RESERVED FOR BINDING

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. **33**

### 1. PLACE OF DEATH:

County Balto  
City or town Registerstown  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
Cockeys Mill Road  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Md. County Balto  
City or town Registerstown  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Cockeys Mill Road  
(If rural, give LOCATION)  
2.(a) If veteran, name war.

### 3. (a) FULL NAME

Edward Grafton Carlisle

### 3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male White Widowed

6.(b) Name of husband or wife

Marietta Carlisle

7. Birth date of deceased (mo., day, yr.)

July 2, 1861

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

87

5

2

hrs.

min.

9. Birthplace

Balto. Co. Md.  
(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

Shoe Business

FATHER

12. Name

David G. Carlisle

13. Birthplace

Balto. Co. Md.

MOTHER

14. Maiden name

Sidney Frances Gill

15. Birthplace

Balto. Co. Md.

16. Informant

Agnes Gill Carlisle

Address

100 W. University Pkwy

17.

(Burial, cremation, or removal, which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Druid Ridge

Location

Balto. Co. Md.

18. Funeral director

William Bok Inc.

Address

1217 St. Paul St.

19.

(Date rec'd by registrar)

12/27

48

G.W. Nedrick

Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH December 24 1948 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 1948 to December 1948

and that I last saw him alive on December 22 1948

Immediate cause of death

Coronary Thrombosis

DURATION

15 min.

Due to

Arteriosclerotic C.V. Disease

10 yrs.

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Martin E. Strobel

M. D. or other

Address

Registerstown, Md.

Date signed 12/24/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.







## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

12168

61

37

## 1. PLACE OF DEATH:

County Baltimore County  
 City or town Carney  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Harford Road

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore  
 City or town Carney  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. Harford Road  
 (If rural, give LOCATION)

2.(a) If veteran, name war no

## 3. (a) FULL NAME

Arthur C. Carroll

## 3. (b) Social Security Number

214-01-7567

4. Sex

male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

married6.(b) Name of husband or wife Mary L. Carroll

6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) February 3, 19078. AGE: Years 41 Months 10 Days 11 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Baltimore, Maryland  
(Town, county, and state)10. Usual occupation Supt.11. Industry or business H. E. Crook Company12. Name William W. Carroll13. Birthplace Baltimore County, Maryland14. Maiden name Birdie Mae Glanville15. Birthplace Baltimore, Maryland16. Informant Mr. William H. CarrollAddress 3501 Longfellow Street, Hyattsvilleburial 12/18/48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Parkwood CemeteryLocation Parkville, Maryland18. Funeral director Wm. Cook, Inc.Address 1217 St. Paul Street19. 12/16 X W. Hedrick

(Date rec'd by registrar) 19. \_\_\_\_\_ Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 14, 19 48 at 10 P.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 10 19 45 to Dec. 14 19 48 and that I last saw him alive on Dec. 14 19 48Immediate cause of death Myocardial degeneration

DURATION

?Due to Rheumatic fever childhood

Due to \_\_\_\_\_

Other conditions disseminated 4 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, pub'c place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE A.M. BaconAddress 2810 Taylor Ave.Date signed 12/15/48

M. D. or other

MARGIN RESERVED FOR BINDING

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

83a

12169

Reg. Dist. No. 35

## 1. PLACE OF DEATH:

County BaltimoreCity or town Towson  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

408 Fairmount Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltimoreCity or town Towson  
(If outside city or town limits, write RURAL and give nearest town)Street No. 408 Fairmount Ave.  
(If rural, give LOCATION)

2(a) If veteran, name war.

## 3. (a) FULL NAME

BERTHA CARROLL

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

Colored

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Levi T. Carroll

6. (c) If alive, give age..... years

## 7. Birth date of

deceased (mo., day, yr.)

July 12, 1891

## 8. AGE:

Years

Months

Days

If less than one day

57511

..... hrs.

..... min.

## 9. Birthplace

West Indies

(Town, county, and state)

## 10. Usual occupation

Housewife

## 11. Industry or business

## FATHER

## 12. Name

William Bradshaw

## 13. Birthplace

West Indies

## MOTHER

## 14. Maiden name

Jane Chanpigny

## 15. Birthplace

West Indies

## 16. Informant

Mr. Levi T. Carroll

## Address

408 Fairmount Ave.

## 17. Burial

(Burial, cremation, or removal. Which?)

## Date thereof

12-28-48

(month) (day) (year)

## Cemetery or crematory

Mt. Auburn Cem.

## Location

Baltimore, Md.

## 18. Funeral director

Mrs. Frances A. Hemsley

## Address

578 W. Biddle St.

Dec 24 1948

(Date rec'd by registrar)

W. H. H. H. H.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 23 19 48 at 3:00 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

December 22

19

48

to

Dec 23

19

48and that I last saw her alive on Dec 22

19

48

Immediate cause of death

apoplexy

DURATION

10 min

Due to

arterio-sclerosis

Due to

hypertension

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(Country)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. H. H. H. H.

M. D. or other

Address

Date signed

12/28/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 15244

## 1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Approximately 5 Hrs.

Hospital, institution, or street address where death occurred:

Vets. Adm. Hospital, Ft. Howard, Md.How long in hospital or institution? Approximately 5 Hrs.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 15 S. Tremont Road  
(If rural, give LOCATION)2. (a) If veteran, name war VN-I

## 3. (a) FULL NAME

BENJAMIN I. CHIDLAW

## 3. (b) Social Security Number

Unknown

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>
-----------------------	----------------------------------	--

6. (b) Name of husband or wife Julia Chidlaw6. (c) If alive, give age 42 years7. Birth date of deceased (mo., day, yr.) 10-8-92

8. AGE:	Years	Months	Days	If less than one day
	<u>56</u>	<u>2</u>	<u>19</u>	hrs. min.

9. Birthplace Philadelphia, Pa.  
(Town, county, and state)10. Usual occupation Construction Work

11. Industry or business

12. Name Benjamin Chidlaw13. Birthplace England14. Maiden name Catherine Irvin15. Birthplace Pennsylvania16. Informant Clinical Records, Vets. Adm. Hosp.Address Fort Howard, Maryland17. Burial Date thereof 12-31-48  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Baltimore National Cemetery  
Baltimore, Maryland

Location

18. Funeral director Farley Funeral HomeAddress Frederick Ave & Shady Nook, Catonsville, Md.19. 12/31/48 19. John S. Connolly  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 27, 1948 at 9:40 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 27, 1948 to December 27, 1948and that I last saw him alive on December 27, 1948

Immediate cause of death <u>Congestive Cardiac Failure due to Arteriosclerotic heart disease</u>	DURATION <u>5 Yrs.</u>
---	---------------------------

Due to plus

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

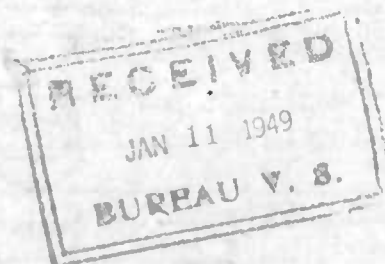
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H.C. MANAUGH M.D. or otherAddress VAH, Ft. Howard, Md. Date signed 12-28-48

152



Evidence for change of  
birth date and age shown  
on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11 JAN 1949

CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH:

County..... Baltimore  
City or town..... Catonsville  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 10 years, 10 months, 13 days  
Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
How long in hospital or institution? 10 years, 10 months, 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State..... Maryland County.....  
City or town..... Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 1811 Harford Ave.  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

3. (a) FULL NAME

Irene Yopps (Coates)

3. (b) Social Security Number

- None

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced divorced

6. (b) Name of husband or wife..... (Arnold Yopps) (Charles Coates)

7. Birth date of deceased (mo., day, yr.) February 6, 1902 (1895)

8. AGE: Years (53) 46 Months 10 Days 15 If less than one day hrs. min.

9. Birthplace..... Maryland (Baltimore)  
(Town, county, and state)

10. Usual occupation..... housewife

11. Industry or business home

12. Name..... James M. Hargest

13. Birthplace..... Maryland

14. Maiden name..... Mary F. Perry

15. Birthplace..... Maryland

16. Informant..... Hospital Records

Address..... Catonsville 28, Md.

17. Burial Date thereof Dec. 23rd, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory..... Loudon Park

Location..... Frederick Rd. Balto: Md.

18. Funeral director..... George J. Ruth, Inc.

Address..... 1735 Harford Avenue

19. Dec 22 19 48 a. w. Hargest  
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 21 19 48, at 3:25a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 8 19 38 to December 21 19 48

and that I last saw her alive on December 21 19 48

Immediate cause of death Right lower lobar pneumonia, undiagnosed DURATION 4 days

Due to.....

Due to.....

Other conditions Prefrontal Lobotomy at Johns Hopkins November 9, 1948  
(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results NO

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Graduate Fred, M.D.

23. SIGNATURE..... M. D. or other

Address..... Date signed .....

MARGIN RESERVED FOR BINDING

VS A15

9-45-12

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Arnold Yopps was never



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. **42**

12172

93d

### 1. PLACE OF DEATH:

County **Balto.**  
City or town **Halethorpe**  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
**4418 Maple Drive**  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State **Md.** County  
City or town **Halethorpe**  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. **4418 Maple Drive**  
(If rural, give LOCATION)  
2. (a) If veteran, name war

### 3. (a) FULL NAME

**NELLIE C. COOKSEY**

### 3. (b) Social Security Number

4. Sex **F.** 5. Color or race **W.** 6. (a) Single, married, widowed, or divorced **Widow**  
6. (b) Name of husband or wife **William M. Cooksey**  
6. (c) If alive, give age years  
7. Birth date of deceased (mo., day, yr.) **December 12, 1875**  
8. AGE: Years **73** Months **0** Days **15** It less than one day hrs. min.

### MEDICAL CERTIFICATION

20. DATE OF DEATH **December 27, 1948** 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **August 10, 1947** to **Dec. 27, 1948**  
and that I last saw her alive on **December 27, 1948**

Immediate cause of death **Cardiac failure** DURATION **2 wks.**

Due to **Arteriosclerotic cardio vascular disease** ?

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE **George A. Krupp M.D.** M. D. or other

Address **3030 Edmondson Avenue** Date signed **Dec. 28, 1948**

9. Birthplace **Baltimore, Md.** (Town, county, and state)  
10. Usual occupation **None**  
11. Industry or business  
12. Name **James C. Whelen**  
13. Birthplace **Canada**  
14. Maiden name **Laura Hagner**  
15. Birthplace **Baltimore, Md.**  
16. Informant Address  
17. **Burial** Date thereof **Dec. 30, 1948**  
(Burial, cremation, or removal, which?) (month) (day) (year)  
Cemetery or crematory **Loudon Park Cem.**  
Location **Baltimore, Md.**  
18. Funeral director **Wm. J. Tickner & Sons**  
Address **Baltimore, Md.**  
19. **12/29** **1948** **D.W. Hedrick** Registrar  
(Date rec'd by registrar)

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. \_\_\_\_\_

### 1. PLACE OF DEATH

County Chase Md.

City or town \_\_\_\_\_  
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: \_\_\_\_\_

Stay in hospital or inst. (yrs., or mos., or days) \_\_\_\_\_

Stay in this community (yrs., or mos., or days) 1 yr.

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Chase

City or town \_\_\_\_\_ Ward No. \_\_\_\_\_  
(If outside city or town limits, write RURAL NEAR and give town)

Street No. \_\_\_\_\_  
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR \_\_\_\_\_

### 3. (a) FULL NAME

Mary Elizabeth Cooper

### 3. (b) Social Security Number

4. Sex

Female

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Widow

6 (b) Name of husband or wife

Braddy Cooper

6 (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.)

July 7, 1880

8. AGE:

Years

Months

Days

If less than one day

68

hrs. min.

9. Birthplace

Hyde Park Md.  
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER  
MOTHER

12. Name

Thomas Perator

13. Birthplace

md.

14. Maiden name

Frances Smith

15. Birthplace

md.

16. Informant

Braddy Cooper Jr.

Address

14000 1st Ave. Box 147, Baltimore

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof Dec. 19, 1948  
(month) (day) (year)

Cemetery or crematory

Sharp St. Cemetery

Location

Baltimore Md.

18. Funeral director

Mr. Dr. A. G. Ellison Daugherty

Address

1129 N. Caroline St.

19. Dec 18, 1948

(Date rec'd by registrar)

NW.

Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH

December 16, 1948 at 4:44 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Apr. 21, 1944 to Dec. 15, 1948  
and that I last saw him alive on Dec. 15, 1948

Immediate cause of death

Chronic Cardio-vascular -  
Renal Disease

DURATION

5 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Df operations no

Df autopsy no

### PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

James H. White, M.D.

M. D. or other

Address

422 Eastern Ave.

Date signed

12/16/48

MARGIN RESERVED FOR BINDING

VSA15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County Balto  
 City or town 341 Della Ave  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Baby Corporal

## 3. (b) Social Security Number

4. Sex

M

5. Color or race

C

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Dec 4. 1948

6. (c) If alive, give age ..... years

8. AGE:

Years

Months

Days

If less than one day

000

hrs.

min. 2

9. Birthplace

Della Md

(Town, county, and state)

10. Usual occupation

none

11. Industry or business

FATHER

12. Name

Randolph Corporal

13. Birthplace

Md

MOTHER

14. Maiden name

Bernice Fincken

15. Birthplace

Md

16. Informant

Randolph Corporal

Address

Della Md

17.

(Burial, cremation, or removal Which?)

Burial

Date thereof

12-4-48  
(month) (day) (year)

Cemetery or crematory

Mt Pilboa

Location

Della Md

18. Funeral director

B C Higginbottom

Address

Elliott City Md

19.

(Date rec'd by registrar)

12-4-48VE. Harry

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Balto

City or town

Della

(If outside city or town limits, write RURAL and give nearest town)

Street No.

341 Della Rd

(If rural, give LOCATION)

2. (a) If veteran, name War

## MEDICAL CERTIFICATION

20. DATE OF DEATH

December 4 1948 at 10 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12-4-1948 to 12-4-48

and that I last saw him alive on ..... 19.....

Immediate cause of death

Asphyxia Pallida

DURATION

?

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

P. J. Maloney

M. D. or other

Address

Certonsville Md

Date signed

12/4/48

RECEIVED

DEC 4 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

### 1. PLACE OF DEATH:

County Baltimore

City or town Spawns Point  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County

City or town Spawns Point  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 817 E St  
(If rural, give LOCATION)

2. (a) If veteran, name war

### 3. (a) FULL NAME

Lennis C. Cronin

### 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male

White

Married

6. (b) Name of husband or wife Mary M. Cronin

7. Birth date of deceased (mo., day, yr.) Jan 24 1875

8. AGE: Years 73 Months 11 Days 6 If less than one day  
hrs. min.

9. Birthplace Wales  
(City, county, and state)

10. Usual occupation Retired

11. Industry or business Bethlehem Steel Co

12. Name Lennis Cronin

13. Birthplace Wales

14. Maiden name Mary

15. Birthplace Wales

16. Informant Mary M. Cronin

Address 817 E St Spawns Point

17. Burial Date thereof Jan 31 49  
(month) (day) (year)

Cemetery or crematory New Baltimore

Location Old Frederick Road

18. Funeral director John C. Moran

Address 3000 E Baltimore St

19. Dec 30 - 48 Dawson L. Frank  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH December 30 19 48 at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19 47 to Dec 30 19 48  
and that I last saw him alive on December 28 19 48

Immediate cause of death Coronary Occlusion

Due to Heart Disease -

sclerotic cardio-vascular disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert E. Farber, M.D.

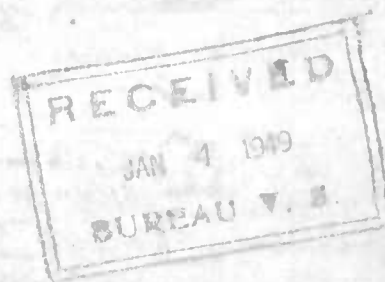
Address Spawns Point, Md Date signed 12-30-48

MARGIN RESERVED FOR BINDING

VS A15

9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1/8  
4/11  
w  
8/6



EVIDENCE FOR CHANGE OF  
AGE SHOW N ON:

FILM No. G

118 JAN 21 1949

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

772

12176

Reg. Dist. No. 40

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

3.(b) Social Security Number

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6.(c) If alive, give age

8. AGE:

Years

Months

Days

It less than one day

9. Birthplace

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19

48

C. E. Arthur

D. Seal Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him

alive on

Immediate cause of death

Acute congestive heart failure with alcoholism

DURATION

Sudden

Due to

Due to

Other conditions

Diabetes insipidus

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 5 1949

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 39

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Manhattan Ind  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BALTIMORE  
 City or town Manhattan - Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

JOHN FREDERICK CUDRY

## 3. (b) Social Security Number

215-10-7465

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MALE WHITE SINGLE

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) JAN 24 - 1884

8. AGE: Years Months Days If less than one day  
64 10 14 \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace MANHATTAN, MD  
(Town, county, and state)10. Usual occupation FARMER

11. Industry or business \_\_\_\_\_

FATHER 12. Name CHARLES E CUDRY13. Birthplace MANHATTAN, MDMOTHER 14. Maiden name ANNA MARY HEISSE15. Birthplace MANHATTAN, MD16. Informant Mrs Ruth CannonAddress Forest H, Lh MD17. Burial Date thereof Dec 11-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Wesley ChapelLocation MANHATTAN, MD18. Funeral director Howard S. MarklineAddress White Hall Ind19. 12/11 48 Anna Price  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 8 19 48 at 4:00 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 19 48 to Dec 8 19 48and that I last saw him alive on Dec 7 19 48

Immediate cause of death

Chronic myocarditis

DURATION

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_

Injured at work? \_\_\_\_\_

23. SIGNATURE A. M. FerenceM. D. 6-11-48Address Parlston, Ind. Date signed 12/10/48

RECEIVED

DEC 15 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

74a

12178

Reg. Dist. No. 34

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Upperco - Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 40 years  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Balto  
 City or town Upperco - Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Charles H Cullison

## 3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced widowed  
 6.(b) Name of husband or wife Gertrude Quincey  
 7. Birth date of deceased (mo., day, yr.) Oct 17 - 1873 6.(c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 75 Months 2 Days 6 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Maryland  
 (Town, county, and state)  
 10. Usual occupation Farmer  
 11. Industry or business own farm  
 12. Name George Cullison  
 13. Birthplace md  
 14. Maiden name Rachel Martin  
 15. Birthplace md

16. Informant Arthur Cullison  
 Address Reisterstown Md  
 17. Burial Date thereof 12-29-48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Grace Methodist  
 Location Balto Co Md  
 18. Funeral director Edward Gipton  
 Address Hampstead Md  
 19. 12-28-48 Mary B. Eline  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 26 1948 a 2 p M  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1947 to December 26 1948  
 and that I last saw him alive on December 26 1948

Immediate cause of death Cerebral Thrombosis DURATION 12 hrs  
 Due to Chronic Myeloid  
Leukemia 12 mrs  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_

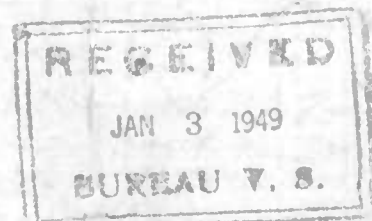
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE Maurice C. Porter Lucid  
 M. D. or other \_\_\_\_\_  
 Address Hampstead, Md Date signed 12-29-48





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

12179

### 1. PLACE OF DEATH

County Baltimore  
City or town Caronsville  
(If outside city or town limits write RURAL and give near at town)

How long in above place of death?  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(If born infants give residence of mother)  
State MARYLAND County Prince Geo  
City or town UPPER MARYBORO  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. BROWN STATION RD.  
(If rural, give LOCATION)

2.(n) If veteran name war NONE ✓

### 3. (a) FULL NAME

CARSON EARL CULVER

### 3. (b) Social Security Number

579-12-4691

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MALE white WIDOWED

6. (b) Name of husband or wife MABEL HOLT

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT. 17-1877

8. AGE: Years Months Days If less than one day hrs. min.  
71

9. Birthplace PA.  
(Town, county, and state)

10. Usual occupation CARPENTER

11. Industry or business SELF EMPLOYED

12. Name MATTHIAS

13. Birthplace PA.

14. Maiden name MATILDA DAVIDSON

15. Birthplace PA.

16. Informant THELMA M. RICE

Address BROWN STATION RD - MALBORO MD.

17. REMOVAL Date thereof Dec. 2, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Wash. D.C.

18. Funeral director W. W. Chambers Co

Address 517-11th ST. SE. WASH. D.C.

19. 12-2 19 48 VE. Harvey Registrar  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 1 19 48 at 11:30 A.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 28 19 48 to Dec 1 19 48

and that I last saw him alive on Dec 1 19 48

Immediate cause of death Hodgkins Disease

DURATION

1 yr

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident suicide or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James Howard M. D. or other

Address Baltimore Date signed 12-2

MARGIN RESERVED FOR BINDING

I

9-45-1

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 6 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

### 1. PLACE OF DEATH:

County Baltimore  
City or town Whitemarsh  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? life  
Hospital, institution, or street address where death occurred:  
Bird River Grove Road  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Balto  
City or town Whitemarsh  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Bird River Grove Road  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

BENJAMIN H. CURNOLLES

### 3. (b) Social Security Number

218-03-3237

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Lottie V. Curnoles

6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) June 25th, 1888

8. AGE: Years 60 Months 5 Days 15 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Balto. Co., Md.  
(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

12. Name Wm. Curnoles

13. Birthplace Balto. Co., Md.

14. Maiden name Annie Bosley

15. Birthplace Balto. Co., Md.

16. Informant Mrs. B. H. Curnoles

Address Bird River Grove Rd., Whitemarsh, Md.

17. burial Date thereof Dec. 13, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Zion United Brethren

Location Black Rock, Md.

18. Funeral director Lassahn Funeral Home

Address 7401 Belair Road

19. 12/11/48 19. \_\_\_\_\_  
(Date rec'd by registrar) Registrar John S. Connolly

### MEDICAL CERTIFICATION

20. DATE OF DEATH December 12th, 1948 at 11 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 26, 1948 to Dec. 10, 1948  
and that I last saw him alive on Dec. 10, 1948

Immediate cause of death Pulmonary Tuberculosis DURATION 5 yrs

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 8 months of death)

Major findings of operations no Date of op. \_\_\_\_\_

Autopsy results no  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE James F. White M.D. M. D. or other  
412 Eastern Ave  
Address Balto. Co., Md. Date signed 12/11/48

MARGIN RESERVED FOR BINDING

VS A15 9.45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 41

## 1. PLACE OF DEATH

County Balto.City or town Sparrows Point  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution or street address where death occurred  
2318 Ruth Ave. EdgemereHow long in hospital or institution? 1 1/2

## 3. (a) FULL NAME

Edgar Rhine Dawson

## 3. (b) Social Security Number

## 4. Sex

M.

## 5. Color or race

W.

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Olga Marie

## 7. Birth date of deceased (mo., day, yr.)

June 14/1927

## 6. (c) If alive, give age..... years

## 8. AGE:

21610hrs.min.

## 9. Birthplace

West Virginia

(Town, county, and state)

## 10. Usual occupation

Laborer

## 11. Industry or business

Bethlehem Steel Co.

## MOTHER FATHER

## 12. Name

Horatio Dawson

## 13. Birthplace

Clara W. Youngblood

## 14. Maiden name

## 15. Birthplace

## 16. Informant

Mrs. Olga M. Dawson  
Address 2318 Ruth Ave., Sparrows Point, Md.

## 17. Burial

(Burial, cremation, or removal, which?)

Date thereof Dec. 27, 1948  
(month) (day) (year)

## Cemetery or crematory

Baltimore National

## Location

Frederick Road

## 18. Funeral director

Roland E. Fisher

## Address

2112 Dundalk Ave.

## 19. Dec. 27

19. 48

(Date rec'd by registrar)

Wm. M. Kelly Jr.  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

## State

## County

## City or town

(If outside city or town limits, write RURAL and give nearest town)

## Street No.

(If rural, give LOCATION)

## 2. (a) If veteran, name War

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

Dec 24 1948 at 4:50 P.M.

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to ..... 19.....

## and that I last saw him..... alive on..... 19.....

## Immediate cause of death

## DURATION

Gunshot wound #16 (Lap gun)  
Lower left chest thru  
heart

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op. ....

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicideDate of 12/24/48

## Where did injury occur?

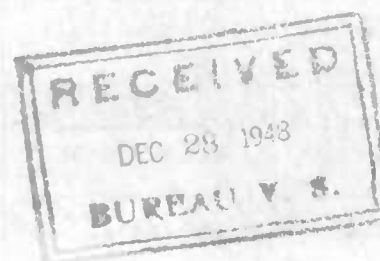
Sparrows Point, Balto., Md.  
(City or town) (County) (State)

## Injured at home, farm, industry, public place (where?)

At homeMeans Gun shot wound chestInjured at work? No

## 23. SIGNATURE

Dr. Margaret M.D.  
Deputy Medical Examiner  
Address Balto., C. Dundalk Date signed 12/24/48





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. 43

## 1. PLACE OF DEATH:

County..... Baltimore  
 City or town..... Raspeburg, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 45 years  
 Hospital, institution, or street address where death occurred:  
 .....  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Baltimore  
 City or town..... Raspeburg, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

AUGUST DEIGERT

## 3. (b) Social Security Number

4. Sex..... male 5. Color or race..... white 6.(a) Single, married, widowed, or divorced..... married  
 6.(b) Name of husband or wife..... Catherine Smith Deigert  
 6.(c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.)..... April 25th, 1903  
 8. AGE: Years..... 45 Months..... 7 Days..... 16 It less than one day..... hrs. .... min.

9. Birthplace..... Baltimore County, Md.  
 (Town, county, and state)  
 10. Usual occupation..... Plasterer  
 11. Industry or business..... Self employed  
 12. Name..... Philip Deigert  
 13. Birthplace..... Baltimore County, Md.  
 14. Maiden name..... Margaret Ellison  
 15. Birthplace..... Baltimore County, Md.  
 16. Informant..... Mrs. August Deigert  
 Address..... 4305 Kenwood Ave.

17. burial Date thereof..... 12/15/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... Holy Redeemer  
 Location..... Baltimore, Md.  
 18. Funeral director..... Lassahn Funeral Home  
 Address..... 7401 Belair Rd.  
 19. 12/15/48 19. 48 Antediluv  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... December 11th, 19..... 48 at..... 11:50 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Nov. 27 19..... 48 to..... DEC. 11 19..... 48  
 and that I last saw him alive on..... Dec. 11 19..... 48

Immediate cause of death..... CARCINOMA OF LUNG DURATION..... 1 YR. +

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings at operation..... CARCINOMA OF LUNG  
 Date of op. Oct. 16th 1947

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Dr. W. H. Hatcher M. D. or other

Address..... 6/33/ Belair Rd. (G) Date signed..... 12/13/48

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County *Balto*City or town *Catonsville*  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Md* CountyCity or town *Balto Co. 2nd*  
(If outside city or town limits, write RURAL and give nearest town)Street *Old Frederick Rd. Stonewall Rd*  
(If rural, give LOCATION) *Catonsville*

2(a) If veteran, name war

## 3. (a) FULL NAME

*Rose Mary Lonnolly*

## 3. (b) Social Security Number

4. Sex

*Female*

5. Color or race

*White*

6. (a) Single, married, widowed, or divorced

*Widow*

6. (b) Name of husband or wife

*Lab Barthelm M. Cox*7. Birth date of deceased (mo., day, yr.) *May 3, 1867*

6. (c) If alive, give age years

8. AGE: Years *81* Months *0* Days *0* If less than one day  
hrs. min.9. Birthplace *Balto*  
(Town, county, and state)10. Usual occupation *Homemaker*

11. Industry or business

12. Name *Frank Cox*13. Birthplace *Ireland*14. Maiden name *Mary Hogan*15. Birthplace *Balto Co Md*18. Informant *Edward B. Lonnolly*Address *Old Frederick Road, Stonewall Rd*17. *Burial* Date thereof *12/16/48*  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory *St. Catharine's*Location *Old Frederick Road*18. Funeral director *John C. Moran*Address *3000 E. Balto St*19. *12-16* 19 *48* *V.E. Harry*  
(Data rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH *Dec-15* 19 *48* at *9:30 A.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*Aug-25* 19 *47* to *Dec-15* 19 *48*and that I last saw him/her alive on *Dec-14* 19 *48*Immediate cause of death *Carcinoma - Stomach*DURATION *2-yrs.*

Due to

Due to

Other conditions *Semibility*

(Include pregnancy within 3 months of death)

Major findings of operations *None*Autopsy results *None*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide *No* Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

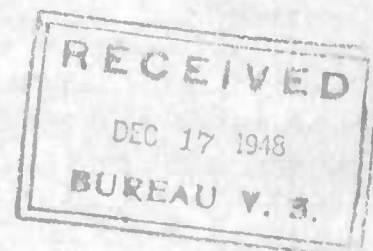
23. SIGNATURE *J. Lloyd Johnson*Address *Catonsville, Md* Date signed *12/16/48*

MARGIN RESERVED FOR BINDING

VS A15

9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County ~~Edwardsville~~ BaltimoreCity or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 15 years, 6 mos 10 days

Hospital, institution, or street address where death occurred:

Spring Grove State HospitalHow long in hospital or institution? 15 years, 6 mos 10 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 2016 Eagle Avenue  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Samuel Dortch

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife

## 7. Birth date of

deceased (mo., day, yr.)

July 16, 1914

## 8. AGE:

Years

Months

Days

If less than one day

34430

hrs.

min.

## 9. Birthplace

Baltimore, Maryland

(Town, county, and state)

## 10. Usual occupation

None

## 11. Industry or business

## FATHER

12. Name Max Dortch13. Birthplace Russia

## MOTHER

14. Maiden name Jennie15. Birthplace Russia

## 16. Informant

Hospital Records

## Address

Catonsville, 28, Md.

## 17.

(Burial, cremation, or removal. Which?)

Date thereof 12-16-48  
(month) (day) (year)

## Cemetery or crematorium

## Location

## 18. Funeral director

## Address

## 19.

(Date rec'd by registrar)

19 48VE. H. H. H.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 15 19 48 at 8:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 5, 1933 19 to Dec. 15 19 48and that I last saw him alive on December 15 19 48

## Immediate cause of death

Terminal pneumonia

## DURATION

24 hoursDue to Acute intestinal obstruction48 "

Due to

Other conditions Birth palsyLife

(Include pregnancy within 3 months of death)

Major findings of operations Acute large bowel distentionDate of op. 12/14/48

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Isadore Tuerk, M. D.

M. D. or other

Address Catonsville, 28, Md. Date signed 12/15/48

RECEIVED

DEC 17 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 42

12185

93d

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Arbutus  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 years  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore  
 City or town Arbutus  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 5522 Thomas ave  
 (If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

George W. Doxzon

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed  
 6. (b) Name of husband or wife late Emily Wood Doxzon  
 6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) May 25-1866

8. AGE: Years 82 Months 6 Days 14 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Maryland  
(Town, county, and state)10. Usual occupation Retired Blacksmith11. Industry or business B & O R. R.12. Name Unknown13. Birthplace Unknown14. Maiden name Unknown15. Birthplace Unknown16. Informant Mr. J. Roland DoxzonAddress 5522 Thomas ave, Arbutus17. Burial Date thereof Dec. 11-1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Mt. Olivet Cem.Location Baltimore, Md18. Funeral director Geo. K. Beyer JrAddress 512 Hollins St Balt. Md19. Dec 10 48 A. W. Hedrick  
(Date rec'd by registrar) (Signature) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 9 1948 at 4:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940 to Dec 9 1948  
 and that I last saw him alive on Dec 6-48 1948

Immediate cause of death Chronic Coronary Arteriosclerosis  
Chronic Myocarditis

## DURATION

6 yr.  
6 yr.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE W. S. Fawcett M. D. or otherAddress 1711 Selma Ave Date signed 12/9/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 37

### 1. PLACE OF DEATH:

County Baltimore  
City or town Cockeysville Md  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 1.2 yrs  
Hospital, institution, or street address where death occurred:  
Masonic Home, Cockeysville Md  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Md County   
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 671 N Fayette St  
(If rural, give LOCATION)  
2.(a) If veteran, name war  ✓

### 3. (a) FULL NAME

Charles Edw. Durschlis

### 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single  
6. (b) Name of husband or wife   
6. (c) If alive, give age  years  
7. Birth date of deceased (mo., day, yr.) June 7 - 1860  
8. AGE: Years 88 Months 5 Days 26 hrs.  min.

9. Birthplace Cincinnati Ohio  
(Town, county, and state)  
10. Usual occupation Shoemaker, Musical Instruments  
11. Industry or business

12. Name Therman Durschlis  
13. Birthplace Hamburg, Germany  
14. Maiden name Mary J. Middleberg  
15. Birthplace St. Louis Mo.

16. Informant Laura M. Schroeder  
Address Masonic Home, Cockeysville  
17. Burial Date thereof Dec 6, 48  
(Burial, cremation, or removal, Which?) (month) (day) (year)  
Cemetery or crematory Grind Ridge  
Location Baltimore Md

18. Funeral director Wm. Cook  
Address St. Paul & Preston St

19. Dec 4 19 48 L.M. Schroeder  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 3 19 48 at 8:30 P.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 19 46 to Dec 3 19 48  
and that I last saw him alive on Dec 3 19 48

Immediate cause of death Cerebral Vascular Accident DURATION 1 day

Due to Arterio sclerosis  
Due to

Other conditions   
(Include pregnancy within 3 months of death)

Major findings of operations  Date of op.

Autopsy results   
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide  Date of   
Where did injury occur?  (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)   
Means of injury  Injured at work?

23. SIGNATURE Walter T. Rees M.D. M. D. or other   
Address Cockeysville Md Date signed 12/3/48

MARGIN RESERVED FOR BINDING

VS-A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

### 1. PLACE OF DEATH:

County Baltimore  
City or town Fort Howard  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 1 day  
Hospital, Institution, or street address where death occurred:  
VAH, Fort Howard, Maryland  
How long in hospital or institution? 1 day

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore  
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 3301 Pulaski Highway  
(If rural, give LOCATION)  
2. (a) If veteran, name war WW I ✓

### 3. (a) FULL NAME

WILLIAM L. ELLIS

### 3. (b) Social Security Number

unknown 2-26-2979

4. Sex MALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced MARRIED-- Sep.

6. (b) Name of husband or wife Agnes Ellis  
6. (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) 9-10-95

8. AGE: Years 53 Months 3 Days 21 It less than one day hrs. min.

9. Birthplace Harford Co., Md.  
(Town, county, and state)

10. Usual occupation Foreman

11. Industry or business

12. Name William Ellis

13. Birthplace Maryland

14. Maiden name Alice White

15. Birthplace Maryland

18. Informant Clinical Records, Vets. Adm. Hosp.  
Address Fort Howard, Md.

17. Burial Date thereof 1/4/49  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Baltimore National Cemetery  
Location 6501 Frederick Rd., Baltimore, Md.

18. Funeral director Blight Funeral Home  
Address 6009 Harford Rd., Baltimore, Md.

19. January 3, 1949 A. W. [Signature]  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH December 31, 1948 at 225 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 30, 1948 to December 31, 1948 and that I last saw him alive on December 31, 1948

Immediate cause of death RUPTURE OF APPENDIX, ABSCESS, PERITONITIS  
Due to Unknown

Due to None  
Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations Substantiated above Date of op.

Autopsy results Substantiated above  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Date of 1-1-49  
Where did injury occur? (City or town) (County) (State)

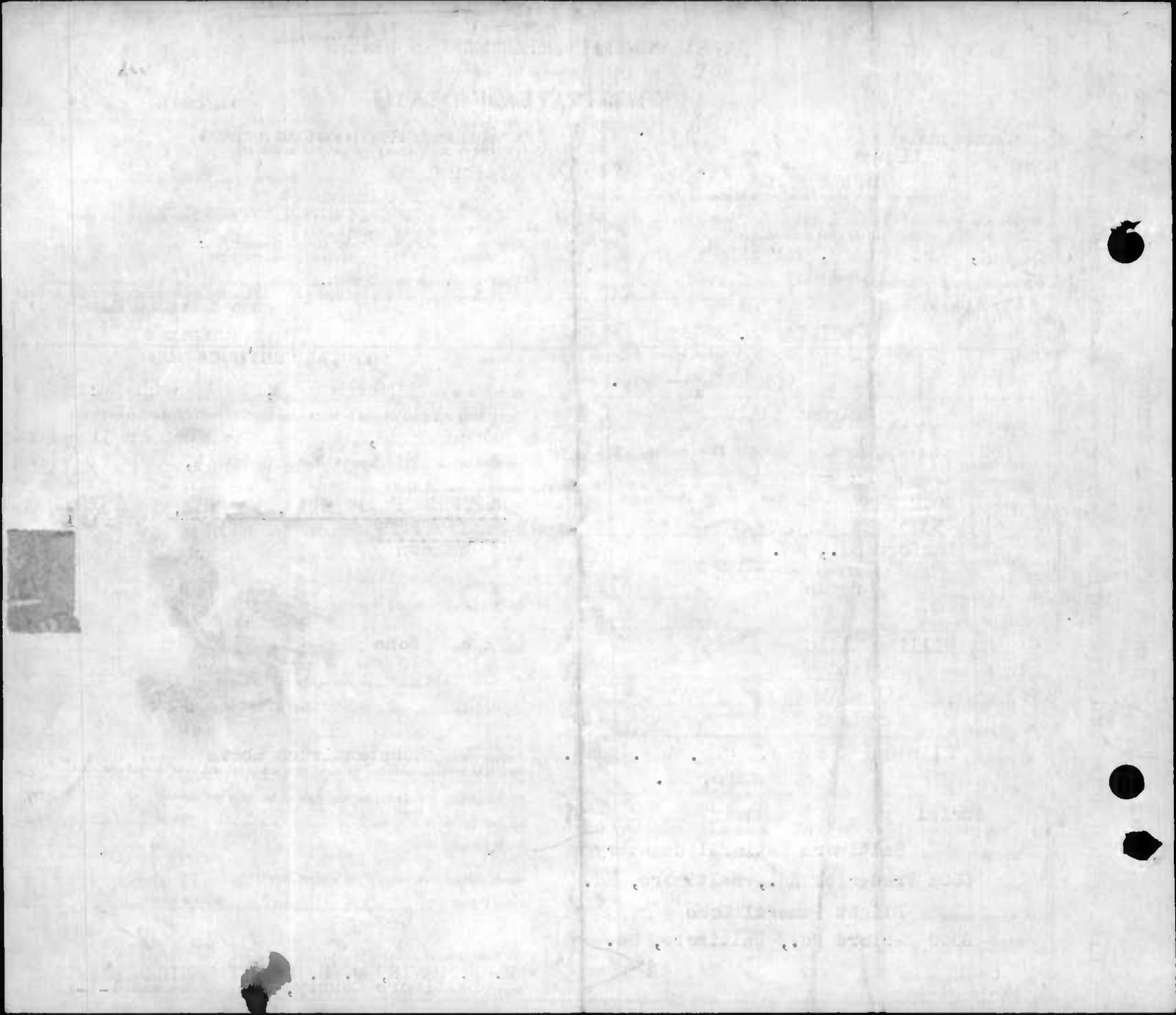
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE M. B. Davis M.D.  
M. B. DAVIS, M. D. DEPUTY MEDICAL EXAMINER  
Address Baltimore County, Md. Date signed 1-1-49

MARGIN RESERVED FOR BINDING

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 12188  
80

## 1. PLACE OF DEATH:

County... **Baltimore**  
 City or town... **Catonsville**  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? **1 month, 10 days**  
 Hospital, institution, or street address where death occurred:  
**Spring Grove State Hospital**  
 How long in hospital or institution? **1 month, 10 days**

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... **Maryland** County... **Prince George**  
 City or town... **Lanham**  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. **Good Luck Road**  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

**Mathias Farman Elsey**

## 3. (b) Social Security Number

4. Sex **male** 5. Color or race **white** 6.(a) Single, married, widowed, or divorced **married**  
 6.(b) Name of husband or wife **Virginia Dixon**  
 6.(c) If alive, give age **33** years  
 7. Birth date of deceased (mo., day, yr.) **May 22, 1909**  
 8. AGE: Years **39** Months **6** Days **29** If less than one day hrs. min.

9. Birthplace **West Virginia**  
 (Town, county, and state)  
 10. Usual occupation **Mechanic**  
 11. Industry or business **Automobile**  
 12. Name **John Garrett Elsey**  
 13. Birthplace **West Virginia?**  
 14. Maiden name **Maxie Mathias**  
 15. Birthplace **West Virginia**  
 16. Informant **Hospital records**  
 Address **Catonsville-28, Maryland**

17. **Burial** Date thereof **Dec 25 1948**  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory **Evergreen Cemetery**  
 Location **Bethesda Md.**  
 18. Funeral director **F. H. H. & Sons**  
 Address **Hyattsville Md.**  
 19. **12-22-48** **V.E. Harry** Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH **December 21** 19 **48** at **5:30 p m**  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **November 11** 19 **48** to **December 21** 19 **48**  
 and that I last saw him alive on **December 21** 19 **48**  
 Immediate cause of death **Acute Hemorrhage**  
 Due to **Rupture of the spleen**  
 Due to  
 Other conditions **Therapeutic malaria**  
 (Include pregnancy within 3 months of death)  
 Major findings of operations  
 Date of op.  
 Autopsy results **as above**  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

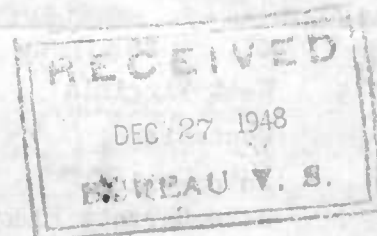
22. VIOLENCE: If death was due to external causes, tell in the following:  
 Accident, suicide, or homicide. Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?  
 23. SIGNATURE **Isadore Turk, M.D.**  
 M. D. or other  
 Address **Catonsville-28, Maryland** Date signed **12-22-48**

MARGIN RESERVED FOR BINDING

9-45-1

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 12189

FILM No. G 118 DEC 22 1948

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Rural near Parkton  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 57 yrs.  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore  
 City or town Rural near Parkton  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1 1/2 Mi. North of Parkton  
 (If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Elizabeth E. Ensor

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow  
 6. (b) Name of husband or wife Peter W. Ensor  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) March 9, 1855  
 8. AGE: Years 93 Months 8 Days 28 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace White Hall, Md. R.D.  
 (Town, county, and state)  
 10. Usual occupation Housewife  
 11. Industry or business Own home  
 12. Name John Miller  
 13. Birthplace Stewartstown, Pa.  
 14. Maiden name Aeriel Thompson  
 15. Birthplace Hartford Co., Md.

16. Informant Miss Rufia Engar  
 Address Parkton, Md. R.D.  
 17. Burial Date thereof 12/12/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory West Liberty Cem.  
 Location White Hall, Md. R.D.  
 18. Funeral director Jacob Hartunglin  
 Address New Freedom, Pa.  
 19. Dec 9 1948 Charles T. Fulton  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 7, 1948 at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 15, 1948 to Dec 7, 1948  
 and that I last saw her alive on Dec 7, 1948

Immediate cause of death Chronic Myocarditis DURATION \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions Arteriosclerosis  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE A. M. Francis M. D. or other \_\_\_\_\_  
 Address Parkton, Md. Date signed 12/5/48

RECEIVED

DEC 17 1948

BUREAU V. S.

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. 40

12190

830a

## 1. PLACE OF DEATH:

County BaltimoreCity or town Hotel Cliff near Towson  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BaltimoreCity or town Hotel Cliff near Towson  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Sr. Mary Lorenzo Esse

## 3. (b) Social Security Number

4. Sex 5. Color of race 6. (a) Single, married, widowed, or divorced

Female White Single

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) March 5, 18598. AGE: Years Months Days If less than one day  
89 9 2 hrs. min.9. Birthplace Rochester, N.Y.  
(Town, county, and state)10. Usual occupation Teacher

## 11. Industry or business

12. Name Pierre Esse13. Birthplace Alsace Lorraine14. Maiden name Ida Kleiber15. Birthplace Hessen Darmstadt16. Informant Sr. Mary ClaraAddress Hotel Cliff17. Burial Date thereof 12-10-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Hotel CliffLocation St. Mary's Church18. Funeral director Sr. M. TurksonAddress 111 N. Wolfe St.19. 12/9/48 19. W. M. Thompson  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 7 1948 at 12.15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 12 1945 to Dec. 7 1948and that I last saw h. Dec. 1 1948Immediate cause of death Apoplexy DURATION 4 days

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE John Green J. W.D. M. D. brotherAddress Towson Date signed Dec 8/48

RECEIVED

DEC 16 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:  
County Baltimore  
City or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 47 years  
Hospital, institution, or street address where death occurred:  
14 Osborne Avenue  
How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Maryland County Baltimore  
City or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 14 Osborne Avenue  
(If rural, give LOCATION)  
2.(a) If veteran, name war

3.(a) FULL NAME  
Harriet Stone Baker Ewalt

3.(b) Social Security Number

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed

6.(b) Name of husband or wife William Henry Ewalt

7. Birth date of deceased (mo., day, yr.) February 10, 1877 6.(c) If alive, give age years

8. AGE: Years 71 Months 10 Days 21 If less than one day hrs. min.

9. Birthplace Baltimore, Maryland  
(Town, county, and state)

10. Usual occupation housewife -- retired

11. Industry or business

12. Name Charles E. Baker

13. Birthplace Baltimore County, Maryland - Athol

14. Maiden name Mary Elizabeth Whiteley

15. Birthplace Herndon, Baltimore Co., Md.

16. Informant Mrs. Evelyn W. Scott

Address 919 E. 5th St., Royal Oak, Mich.

17. Burial Date thereof 1 - 3 - 49  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery Loudon Park

Location 3801 Frederick Ave., Baltimore, Md.

18. Funeral director John C. Mitchell & Sons, Inc.

Address 1900 Eutaw Place, Baltimore, Md.

19. Jan 3 1949 W.E. Harry  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH December 31 1948 at 5:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 30 1948 to December 31 1948  
and that I last saw him alive on December 31 1948

Immediate cause of death Hepatic arterio-

Due to arterio-sclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address 20 E. Preston St. Date signed 12/31/48  
Baltimore 2, Md.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

JAN 6 1949

BUREAU V. S.



WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

B.---Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

Village or City Hyde Park (No. \_\_\_\_\_)

2 FULL NAME Cora E. Fisher

12192  
STATE OF MARYLAND  
CERTIFICATE OF DEATH

94a  
Registration Dist. No. 44

Galena Road (If death occurred in a hospital or institution, give its NAME instead of street and number.)  
Ward \_\_\_\_\_

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH April 27th 1880  
(Month) (Day) (Year)

7 AGE 68 yrs. 7 mos. 25 ds. or min.?  
If LESS than 1 day.....hrs.

8 OCCUPATION  
(a) Trade, profession or particular kind of work at home  
(b) General nature of industry business, or establishment in which employed or (employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Middlesex Co. Va.

10 NAME OF FATHER John Montgomery

11 BIRTHPLACE OF FATHER Va.  
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER Va.  
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Philma Hearn  
(Address) 2424 Llewellyn Ave

15 Filed Dec. 24th 1948 A.W. Hadwick  
R.W. Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH December 22, 1948  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Dec 2 1948 to Dec 22 1948  
that I last saw her alive on Dec 21 1948  
and that death occurred on the date stated above, at 6 P. m.

The CAUSE OF DEATH \* was as follows:

Coronary Thrombosis

Contributory Secondary Hypertension  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 20 ds.

(Signed) M.A. Jacobs M. D.  
Dec 22 1948 (Address) 617 North H. Road

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Beltaville Va. DATE OF BURIAL Dec 26th 1948

20 UNDERTAKER William Cook Inc ADDRESS 1217 St. Paul St. Balto. Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return 'Laborer,' 'Foreman,' 'Manager,' 'Dealer,' etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia, Bronchopneumonia, "Pneumonia,"*

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc.*, of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County..... Baltimore  
 City or town..... Essex, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 30 years  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... Md. County..... Baltimore  
 City or town..... Essex, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 903 Mace Ave.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Theodore Flatt

## 3. (b) Social Security Number

213-07-1265

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Augusta Gellert Flatt  
 7. Birth date of deceased (mo., day, yr.) September 26th, 1886  
 8. AGE: Years 62 Months 3 Days 2 If less than one day hrs. min.

9. Birthplace Poland (Town, county, and state)  
 10. Usual occupation Tinner  
 11. Industry or business Bethlehem Steel Co.  
 12. Name Gustav Flatt  
 13. Birthplace Poland  
 14. Maiden name Fredericka Kirk  
 15. Birthplace Poland

18. Informant Mrs. Theodore Flatt  
 Address 903 Mace Ave.

17. burial Date thereof 12/31/48 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Zion Lutheran  
 Location Stemmers Run, Md.

18. Funeral director Lassar Funeral Home  
 Address 7401 Belair Rd.

19. 12/29 1948 R. W. Hedrick Registrar  
 (Date rec'd by Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 28 1948 at 8 A M  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 27 1948 to Dec 28 1948 and that I last saw him alive on Dec 28 1948  
 Immediate cause of death Coronary Thrombosis  
 Due to Arterio-sclerotic cardiac valvular disease  
 Due to Sudden  
 Other conditions  
 (Include pregnancy within 8 months of death)

Major findings of operations  
 Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE [Signature] M. D. or other  
 Address Balto 6 Date signed 12-28-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

12194

Reg. Dist. No. 42

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Arbutus  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 21 months  
 Hospital, institution, or street address where death occurred:  
1249 Sulphur Spring Road  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore  
 City or town Arbutus  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1249 Sulphur Spring Road  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

William Lewis Fowble

## 3. (b) Social Security Number

with 216-10-8710

## 4. Sex

Male

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

married

## 6. (b) Name of husband or wife

Mary Agnes Fowble

## 7. Birth date of deceased (mo., day, yr.)

Nov. 3, 1877

## 6. (c) If alive, give age \_\_\_\_\_ years

63

## 8. AGE:

Years

Months

Days

If less than one day

71126

hrs.

min.

## 9. Birthplace

Carroll County, Md  
(Town, county, and state)

## 10. Usual occupation

daily employee

## 11. Industry or business

daily

MOTHER FATHER

## 12. Name

Oliver Pierce Fowble

## 13. Birthplace

Carroll County, Md

## 14. Maiden name

Mary Catherine Fowble

## 15. Birthplace

Carroll County, Md

## 16. Informant

Hedy Fowble

## Address

1249 Sulphur Spring Road

## 17. Burial

(Burial, cremation, or removal. Which?)

## Date thereof

Dec 31/48  
(month) (day) (year)

## Cemetery or crematory

Emory Methodist

## Location

Carroll Co Md

## 18. Funeral director

Edw Jipton

## Address

Hampstead Ind

## 19.

(Date rec'd by registrar)

12/29 48  
Dr. Delich Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 29 19 48 at 1:00 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 20 19 48 to Dec 28 19 48and that I last saw him alive on December 28 19 48Immediate cause of death Coronary Occlusion

## DURATION

1 hourDue to Arteriosclerotic heart disease years

Due to \_\_\_\_\_

Other conditions Virus Pneumonia 1 week

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE William Goodman, M.D.Address 1334 Sulphur Spring Road Date signed 29 Dec 48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 9

12195

1. PLACE OF DEATH: B&O.  
724 Arundale Rd.  
 County Bundale  
 City or town Bundale  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 13 yrs  
 Hospital, institution, or street address where death occurred:  
13 yrs  
 How long in hospital or institution? 13 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)

State Md County Bundale  
 City or town Bundale  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 724 Arundale Rd.  
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Robert Fowler

3. (b) Social Security Number

4. Sex Male 5. Color or race Col. 6.(a) Single, married, widowed, or divorced Widower  
 6.(b) Name of husband or wife Nora  
 7. Birth date of deceased (mo., day, yr.) Feb. 9, 1887  
 6.(c) If alive, give age..... years  
 8. AGE: Year 61 Months..... Days..... If less than one day..... hrs. .... min.

9. Birthplace Charlotte Co. Va.  
 (Town, county, and state)

10. Usual occupation Retired

11. Industry or business

12. Name Unknown

13. Birthplace

14. Maiden name Jane Spencer

15. Birthplace Va.

16. Informant Lizzie Brown Carter

Address 724 Arundale Road

17. Removal Date thereof Dec 24/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Drakes Branch Va.

18. Funeral director Mrs. Robert G. Elliott & Daugherty

Address 1129 N. Caroline St

19. 12/27 19 48 A. W. Hedrick  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-22-48 19 48 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-1-48 19 48 to 12-22-48 19 48  
 and that I last saw him alive on 12-22-48 19 48

Immediate cause of death

Hemiplegia, hypertensive

Due to arteriosclerosis, senility

Due to

Other conditions 12/22/48

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Arthur F. Brown 12/27

M. D. or other

Address 123 N. Caroline St Date signed 12-22-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

12196

43

## 1. PLACE OF DEATH

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him..... alive on.....

Immediate cause of death.....

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

Address.....

Date signed.....



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

### 1. PLACE OF DEATH:

County Baltimore  
City or town Glyndon  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 50 yrs  
Hospital, institution, or street address where death occurred:  
  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore  
City or town Glyndon  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Longnecker Road  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Florence E. Frantz

### 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed  
6.(b) Name of husband or wife Ernest M. Frantz  
6.(c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) July 2, 1869  
8. AGE: Year 79 Month 5 Days 26 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Maryland  
(Town, county, and state)  
10. Usual occupation Housewife  
11. Industry or business

FATHER 12. Name Martin Kendig  
13. Birthplace Penna  
MOTHER 14. Maiden name Barbara Trout  
15. Birthplace Penna.

16. Informant E. Wilton Frantz  
Address Glyndon, Md.  
17. Burial Date thereof Dec. 31, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Druid Ridge  
Location Balto. Co.

18. Funeral director J. F. Eline, Sons  
Address Reisterstown, Md.

19. 12-30-48 Mary B. Eline  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 28 19 48 at 6:57 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-10 19 45 to 12-28 19 48  
and that I last saw her alive on 12-28 19 48

Immediate cause of death Acute myocardial infarction DURATION 3 hrs  
Due to arteriosclerosis & V. Disease 3 yrs

Due to \_\_\_\_\_  
Other conditions Hypertension & V. D. 3 yrs  
Interventricular Protrusion 3 yrs  
(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work?

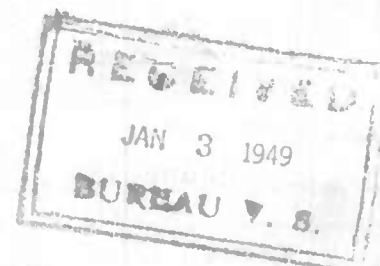
23. SIGNATURE D. D. Caples, M.D. M. D. or other  
Address Reisterstown, Md. Date signed 12-29-48

MAINTAIN RESERVED FOR BINDING

9-45-15

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

12198

Reg. Dist. No. 41

## 1. PLACE OF DEATH:

County Balto.  
City or town Burndale 22 Md  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

Female

5. Color or race

col

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

158

hrs.

min.

9. Birthplace

Balto, Co.

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date recd by registrar)

19.

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## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec 30, 1948 at 1:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to 19.....

and that I last saw him alive on 19.....

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Manner of injury

Injured at work?

23. SIGNATURE

Address

Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 4X

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Fort Howard, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 397 days  
 Hospital, institution, or street address where death occurred:  
Vets. Adm. Hospital, Fort Howard, Md.  
 How long in hospital or institution? 397 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County \_\_\_\_\_  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 502 N. Castle St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war WW II

## 3. (a) FULL NAME

SARAH LEE GAPHARDT

## 3. (b) Social Security Number

Unknown

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife James Gaphardt  
 6.(c) If alive, give age 34 years  
 7. Birth date of deceased (mo., day, yr.) April 15, 1922  
 8. AGE: Years 26 Months 8 Days 8 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Leonardtown, Maryland  
 (Town, county, and state)  
 10. Usual occupation Housewife  
 11. Industry or business \_\_\_\_\_  
 12. Name Albert Waranch  
 13. Birthplace Russia  
 14. Maiden name Yettas Addis  
 15. Birthplace Russia

16. Informant Clinical Records, Vets. Adm. Hosp.  
 Address Fort Howard, Maryland  
 17. Burial Date thereof 12-26-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Hebrew Herring Run  
 Location Baltimore, Md.  
 18. Funeral director Jack Lewis Funeral Home  
 Address 2100 Eutaw Place, Baltimore, Md.  
 19. In 24 48  
 (Date rec'd by registrar) Registrar [Signature]

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 23 19 48 at 8:18 P. M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 22 19 47 to December 23 19 48  
 and that I last saw her alive on December 23 19 48

Immediate cause of death GENERALIZED CARCINOMATOSIS  
 DURATION 14 mos.  
 Due to Adenocarcinoma of Colon 4 yrs.  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results none  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE H.C. MANAUGH  
H.C. MANAUGH, M.D. Chief No. or other \_\_\_\_\_  
 Address VAH, FORT HOWARD, MD. Date signed \_\_\_\_\_

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

12200

Reg. Dist. No. 33

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Glyndon  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 weeks  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3.(a) FULL NAME

Bruce Arthur Gearhart

## 3.(b) Social Security Number

202-18-0412

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male

White

Married SINGLE

6.(b) Name of husband or wife Ester Barker Gearhart

6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Jan. 21, 19208. AGE: Years Months Days If less than one day  
28 11 6 \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Hagerstown, Md.  
 (Town, county, and state)10. Usual occupation Plumber

## 11. Industry or business

12. Name Lemual Bruce Gearhart13. Birthplace Md.14. Maiden name Nellie Gorsuch15. Birthplace W. Virginia16. Informant Mrs. Ester B. GearhartAddress Glyndon, Md.17. Burial Date thereof Dec. 29, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose HillLocation Hagerstown, Md.18. Funeral director J. F. Eline SonsAddress Reisterstown, Md.19. 12-28-48 Mary B. Eline  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 27 1948, at 10:45 A.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
12-27-'48 19\_\_\_\_, to 12-27-'48 19\_\_\_\_and that I last saw him alive on not seen alive 19\_\_\_\_

Immediate cause of death \_\_\_\_\_ DURATION

Laundry boiler exploded &  
blew his head off & eviscerated  
him Instant

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

NONE Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

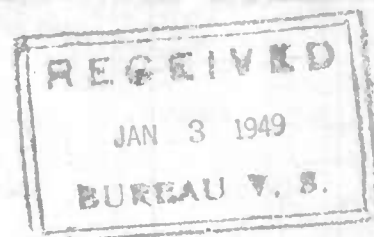
22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 12-27-'48Where did injury occur? Glyndon, Balto., Md.  
 (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Glyndon LaundryMeans of injury Boiler exploded Injured at work? Yes23. SIGNATURE D. D. Caples, M.D. med. Exam.  
 M. D. or otherAddress Reisterstown, Md. Date signed 12-27-'48

MARGIN RESERVED FOR BINDING

VS A15 9.45.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH.

Reg. Dist. No.

12201

44

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

66

5

10

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

212-10-2250

## MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

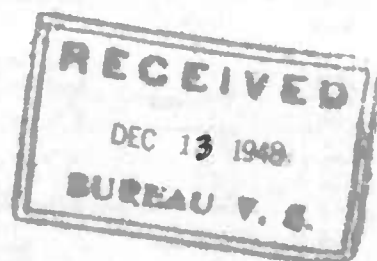
Injured at work?

23. SIGNATURE

Address

or other

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Fort Howard  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 days  
 Hospital, institution, or street address where death occurred:  
V. A. H., Fort Howard, Maryland  
 How long in hospital or institution? 2 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County   
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3643 Cottage Avenue  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war WW I

## 3. (a) FULL NAME

BENJAMIN GLASSMAN

## 3. (b) Social Security Number

216012986

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Mrs. Edith Glassman  
 6. (c) If alive, give age 54 years  
 7. Birth date of deceased (mo., day, yr.) December 18, 1889  
 8. AGE: Years 58 Months 11 Days 29 It less than one day hrs. min.

9. Birthplace New York City  
 (Town, county, and state)  
 10. Usual occupation Salesman  
 11. Industry or business   
 12. Name Myer Glassman  
 13. Birthplace Russia  
 14. Maiden name Fannie Mervis  
 15. Birthplace Russia

18. Informant Clinical Records, Vet. Adm. Hosp.  
 Address Fort Howard, Maryland  
 17. Burial Date thereof 12-19-48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Hebrew Friendship Cemetery  
 Location 3600 E. Baltimore St., Balto., Md.  
 18. Funeral director Jack Lewis, Inc.  
 Address 2100-2102 Eutaw Place, Balto., Md.

19. 12/19/48 19 Huntington Williams, M.D.  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 17, 1948 at 8:55A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
December 15, 1948 to December 17, 1948  
 and that I last saw him alive on December 17, 1948

Immediate cause of death ACUTE CORONARY OCCLUSION DURATION 2 days

Due to

Due to

Other conditions

CORONARY SCLEROSIS WITH INSUFFICIENCY 2 yrs.  
 (Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

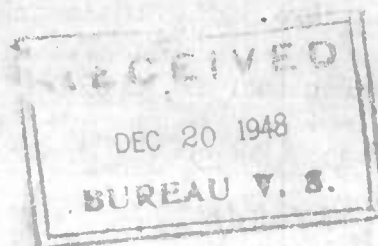
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. C. MANAUGHH. C. MANAUGH, M. D., CHIEF, PRO. SER. eesAddress FORT HOWARD, MARYLAND Date signed 12-17-48



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 38

1. PLACE OF DEATH

(a) Baltimore City, Maryland  
(b) Street address 812 Regester Ave.  
(c) Hospital or institution: Anacostia Nursing Home  
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 mos.  
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County...  
(c) City or town Baltimore  
(If outside city or town limits, write RURAL and give town)  
(d) Street No. 3127 Cranford Ave.  
(If rural give location)  
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME

Isa M. Fontana (Contram)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

5-16-1879

8. AGE:

Years

Months

Days

If less than one day

69

7

11

hr.

min.

9. Birthplace

Baltimore, MD.

(Town, county, and state)

10. Usual Occupation

at home

11. Industry or business

FATHER

12. Name

Turner

13. Birthplace

not known

MOTHER

14. Maiden Name

not known

15. Birthplace

not known

16 (a) Informant

Charles H. Fontana

(b) Address

3127 Cranford Ave.

17 (a)

Burial, cremation, or removal

(b) Date thereof

2/7/48

(month) (day) (year)

(c) Cemetery or crematory

Northland Memorial

Location

Baltimore, Co.

18 (a) Funeral director

E. J. Jarry & Son

(b) Address

1938 E. Lafayette Ave.

19 (a)

12/28/48

(b)

J. H. Dedrick

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 27 1948, at 4:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 11 1948, to Dec. 27 1948, and that I last saw her alive on Dec. 26 1948.

Immediate cause of death

Cerebral thrombosis

Duration

16 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature

Wm. J. Jarry

Address 701 N. Maryland

Date signed 12/27/48

PHYSICIAN

Underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 1277

## 1. PLACE OF DEATH:

County Edm. 19  
City or town Edgemere, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 4 yrs  
Hospital, institution, or street address where death occurred:  
101 Oak Ave  
How long in hospital or institution? 4 yrs

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Md. County Edgemere  
City or town Edgemere  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 101 Oak Ave  
(If rural, give LOCATION)  
2.(a) If veteran, name war

## 3. (a) FULL NAME

Hester Gregory

## 3. (b) Social Security Number

4. Sex Female 5. Color or race Col 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Wallace

B.(c) If alive, give age. years

7. Birth date of deceased (mo., day, yr.) Oct 20, 1899

8. AGE: Years 49 Months 0 Days 0 If less than one day hrs. min.

9. Birthplace Isle White Co. Va.  
(Town, county, and state)

10. Usual occupation housewife

11. Industry or business

12. Name John Darter

13. Birthplace Isle White Co. Va.

14. Maiden name Anna Darter

15. Birthplace Prince George Co. Va.

16. Informant Wallace Gregory

Address 101 Oak Ave. Edgemere

17. Burial Date thereof 12/23/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Windsor Ma

18. Funeral director Mrs. Ruth A. Elliott & Son

Address 1129 N. Caroline St

19. 12/23 19 48 R. W. Hester  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-21-48 19 48 at 11 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 48 to Dec 21 19 48

and that I last saw him alive on Dec 21 19 48

Immediate cause of death Coronary Heart Failure

2. Diabetic Mellitus

Due to usual - hyperinsulin

Due to usual

Other conditions Diabetes Mellitus

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Arthur D. Hester M. D. or other

Address 423 New Richmond Ave Date signed





RECEIVED

JAN 4 1949

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

12206

Reg. Dist. No. 34

## 1. PLACE OF DEATH

County Baltimore  
 City or town Hampstead Md.  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:  
Hampstead Md.

How long in hospital or institution?

## 3. (a) FULL NAME

Laura Kate Hale

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Jacob F. Hale

7. Birth date of deceased (mo., day, yr.)

Sept. 13 - 1869

6. (c) If alive, give age 83 years

8. AGE:

Years 79 Months 3 Days 0 It less than one day  
 hrs. min.

9. Birthplace

Albanatown Md.  
 (Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Home

FATHER

12. Name

Thomas Alban

13. Birthplace

Maryland

MOTHER

14. Maiden name

Rush

15. Birthplace

Maryland

16. Informant

Jacob F. Hale

Address

Hampstead Md.

17. (Burial, cremation, or removal. Which?)

Buried Date thereof Dec 15-48  
 (month) (day) (year)

Cemetery or crematory

Grave Run

Location

Balto co Md

18. Funeral director

Edw. E. Griston

Address

Hampstead Md

19. 12-14- 19 48  
 (Date rec'd by registrar)

Mary B. Elmer  
 Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Albanatown  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 13, 19 48 at 1 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 4, 19 40, to Dec 13, 19 48  
 and that I last saw him alive on Dec 4, 19 48

Immediate cause of death

Chronic Myocarditis

DURATION

Due to

Hypertensive Cardiac  
Renal, Vascular Disease

Due to

Cerebral Hemorrhage

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. \_\_\_\_\_

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: if death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE

Edw. M. Bush M.D.

Address Hampstead Md Date signed 12/13/48





RECEIVED

DEC 16 1948

BUREAU V. S.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 83a 122044

### 1. PLACE OF DEATH:

County Baltimore  
City or town Fort Howard  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 2 Days  
Hospital, institution, or street address where death occurred:  
Vet. Adm. Hospital, Ft. Howard, Md.  
How long in hospital or institution? 2 Days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll  
City or town Westminster  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 14 1/2 Willis St.  
(If rural, give LOCATION)  
2. (a) If veteran, name war WWI

### 3. (a) FULL NAME

HARRY V. HARBAUGH

### 3. (b) Social Security Number

UNKNOWN (none)

4. Sex MALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced DIVORCED

6. (b) Name of husband or wife Divorced

1. Birth date of deceased (mo., day, yr.) July 24, 1893 6. (c) If alive, give age..... years

8. AGE: Years 55 Months 5 Days 0 If less than one day..... hrs. .... min.

9. Birthplace Westminster, Maryland  
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business Auto dealer

12. Name Harry Harbaugh

13. Birthplace Maryland

14. Maiden name Sally Fleagle

15. Birthplace Maryland

16. Informant Clinical Records, Vets. Adm. Hosp.

Address Fort Howard, Maryland

17. Burial Date thereof 12/28/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Baltimore National Cemetery

Location Baltimore, Md.

18. Funeral director J. Francis Reese

Address F. A. Sharrer & Son

Westminster, Md.

19. Dec 28, 1948 Darwin L. Harby  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH December 24 19 48 at 11:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 22 19 48, to December 24 19 48 and that I last saw him alive on December 24 19 48

Immediate cause of death CEREBRAL HEMORRHAGE DURATION 3 days

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles C. Shaw M. D. or other

Address FORT HOWARD, MARYLAND Date signed 12-21-48

MARGIN RESERVED FOR BINDING

VS A15

9-45-18

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 3 1949

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

## 1. PLACE OF DEATH:

County 804 Overbrook Rd  
 City or town Baltimore 12 Towson  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Balto. County  
 City or town Baltimore County  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 804 Overbrook Rd 12  
 (If rural, give LOCATION)

2.(c) If veteran, name war

## 3. (a) FULL NAME

Russell N. Hardcastle

## 3. (b) Social Security Number

4. Sex m. 5. Color of race W. 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Laura E. Hardcastle7. Birth date of deceased (mo., day, yr.) Aug 24, 1893 6. (c) If alive, give age \_\_\_\_\_ years8. AGE: Years 55 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Delaware (Town, county, and state)10. Usual occupation Service Manager11. Industry or business Auto German Motor Co12. Name William A. Hardcastle13. Birthplace Delaware14. Maiden name Mary Jones15. Birthplace Delaware16. Informant Laura E. HardcastleAddress 804 Overbrook Rd17. Burial Date thereof 12-14-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory ParkwoodLocation Taylor Ave18. Funeral director John A. MoranAddress 3600 E. Baltimore St.19. Dec 13 48 19 48 A.W. Hedrick  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 11 1948 at 8:30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_ and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_

Immediate cause of death Coronary Occlusion. DURATION Sudden.  
Anterior Infarction. W.H.K.

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE John J. Lacey M.D.  
Luzon - 4 12/11/48  
Deputy Medical Examiner

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12210

## CERTIFICATE OF DEATH

Reg. Dist. No. 3730

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Cockeysville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 6 weeks  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Baltimore  
 City or town Cockeysville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. York Road  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Marlene Myrtle Hare

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single  
 6. (b) Name of husband or wife \_\_\_\_\_  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) November 11, 1948  
 8. AGE: Years \_\_\_\_\_ Months 1 Days 4 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Cockeysville, Balt., Md.  
 (Town, county, and state)  
 10. Usual occupation \_\_\_\_\_  
 11. Industry or business \_\_\_\_\_

12. Name Leroy Hare  
 13. Birthplace Beckleysville, Carroll Co. Md.  
 14. Maiden name Catherine Daisy Hoffman  
 15. Birthplace Parkton, Balt. Co. Md.

16. Informant Leroy Hare  
 Address Cockeysville, Md.

17. Burial Burial Date thereof Dec. 24, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Middletown Cemetery  
 Location Freeland Md. R.D.

18. Funeral director Jacob Bartenstein  
 Address New Freedom, Pa.

19. Dec 24 1948 Charles L. Jackson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 22 December 1948 at 12:10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
11 November 1948 to 22 December 1948  
 and that I last saw her alive on 22 December 1948

Immediate cause of death Pneumonia - lobar DURATION 1 day

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Walter T. Kees M.D.

Cockeysville, Md. M. D. or other \_\_\_\_\_  
 Address \_\_\_\_\_ Date 22 Dec. 1948

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 5 1949

BUREAU V. S.

131a

# CERTIFICATE OF DEATH

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:				2. HOME (USUAL RESIDENCE) OF DECEASED:			
(a) County <u>Baltimore</u>				(a) State <u>Md.</u> (b) County <u>Baltimore</u>			
(b) City or town <u>Hebbsville</u> (If outside city or town limits, write RURAL and give town)				(c) City or town <u>Hebbsville</u> (If outside city or town limits, write RURAL and give town)			
(c) Street address, hospital, or institution: <u>Rolling Road</u>				(d) Street No. <u>Rolling Road</u> (If rural give location)			
(d) Length of stay in hospital or inst. (yrs., mos., or days)				(e) If foreign born, how long in U. S. A. ? _____ years			
(e) Length of stay in this community (yrs., mos., or days) <u>24 yrs.</u>							
3 (a) FULL NAME <u>Joseph Russell</u> ( <u>Russell Joseph</u> ) <u>Harrison</u>							
3 (b) If veteran, name war		3 (c) Social Security No. <u>212-05-0601</u>		MEDICAL CERTIFICATION			
4. Sex <u>Male</u>		5. Color or race <u>White</u>		20. Date of death <u>Dec 5</u> 19 <u>48</u> at <u>2:45</u> P. M.			
6 (a) Single, married, widowed, or divorced. <u>Married</u>		21. I certify that death occurred on the date above stated; that I attended deceased from <u>Dec 1</u> 19 <u>47</u> to <u>Dec 5</u> 19 <u>48</u> and that I last saw him alive on <u>Dec 5</u> 19 <u>48</u> .					
6 (b) Name of husband or wife <u>Dorothy C. Harrison</u>		Immediate cause of death <u>Coronary Thrombosis</u> Duration <u>12 hrs</u>					
6 (c) If alive, give age <u>43</u> years		Due to <u>Arteriosclerosis</u> <u>Uncertain</u>					
7. Birth date of deceased (mo., day, yr.) <u>March 29, 1904</u>		Due to <u>High Blood Pressure</u> <u>Uncertain</u>					
8. AGE: Years <u>44</u> Months <u>8</u> Days <u>6</u> If less than one day _____ hr. _____ min.		Other conditions <u>Chronic Nephritis</u> <u>Uncertain</u>					
9. Birthplace <u>Baltimore County, Md.</u> (Town, county, and state)		(Include pregnancy within 8 months of death)					
10. Usual occupation <u>Switch Board Installer</u>		Major findings: <u>No operation</u>					
11. Industry or business <u>C &amp; P Telephone Co.</u>		Of operations _____					
12. Name <u>Joseph William Harrison</u>		Of autopsy <u>No autopsy</u>					
13. Birthplace <u>Maryland</u>		22. If death was due to external causes, fill in the following:					
14. Maiden Name <u>Olivia Peoples</u>		(a) Accident, suicide, or homicide _____					
15. Birthplace <u>Maryland</u>		(b) Date of occurrence _____					
16 (a) Informant <u>Mrs. Dorothy C. Harrison</u>		(c) Where did injury occur? _____ (City or town) (County) (State)					
16 (b) Address <u>Rolling Road, Hebbsville, Md.</u>		(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____ (Specify type of place)					
17 (a) <u>Burial</u> (Burial, cremation, or removal)		(e) Means of injury _____					
17 (b) Date thereof <u>Dec. 8, 1948</u> (month) (day) (year)		23. Signature <u>Joshua H. Amador</u> M. D. or other <u>MD</u>					
17 (c) Cemetery or crematory <u>Lorraine Cemetery</u>		Address <u>64194 Windsor Dr</u> <u>Baltimore - 7 Md</u>					
17 (d) Location <u>Bethesda Co.</u>							
18 (a) Funeral director <u>W. L. L. L. L. L.</u>							
18 (b) Address <u>4510 Liberty Heights Ave.</u>							
19 (a) <u>Dec 7-48</u> (Date rec'd by registrar)							
19 (b) <u>a. w. Hudson</u> Registrar							



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

12212  
37

## 1. PLACE OF DEATH:

County..... Balto.City or town..... Kingsville P. O.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md. County..... Baltimore.City or town..... Kingsville P. O.  
(If outside city or town limits, write RURAL and give nearest town)Street No.....  
(If rural, give LOCATION)2.(a) If veteran, name war..... no

## 3. (a) FULL NAME

Mr. Charles Albert Harryman

## 3. (b) Social Security Number

## 4. Sex

M.

## 5. Color or race

W.6. (a) Single ☒ married ☐ widowed, or divorced6. (b) Name of husband or wife..... Mrs. Bertha M. Harryman7. Birth date of deceased (mo., day, yr.) April 7 - 1875  
6. (c) If alive, give age..... years8. AGE: Years Months Days If less than one day.  
73 8 7 ..... hrs. min.9. Birthplace..... Baltimore, Md.  
(Town, county, and state)10. Usual occupation..... retired.

## 11. Industry or business

12. Name..... Mr. Thomas Harryman13. Birthplace..... Perryman, Md.14. Maiden name..... Mary Pasqualina Bayley15. Birthplace..... St. Michael, Md.16. Informant..... Mrs. Bertha M. Harryman, wife  
Kingsville, Md.

Address.....

17. Burial Date thereof..... 12/18/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory..... Loudon Park Cem.Location..... Balto., Md.18. Funeral director..... WM. J. TICKNER & SONSAddress..... Balto., Md.19. 12-16-48 Registrar

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... December 14, 1948 at 8:20 P.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
December 1st, 1948 to Dec 14, 1948  
and that I last saw him alive on December 14, 1948

Immediate cause of death.....

Cachexia -Bronchopneumonia

Due to.....

Carcinoma ofDue to..... esophagus

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Carcinoma of  
esophagus Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE..... John F. Noguera MDAddress..... Kingsville, Md. Date signed..... 12/14/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH *Be*  
2411 N. Charles St., Baltimore *186a*  
CERTIFICATE OF DEATH

12213

Reg. Dist. No. *30*

## 1. PLACE OF DEATH:

County *Baltimore*  
City or town *Catonsville*  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? *19 years, 9 months*  
Hospital, institution, or street address where death occurred:  
*Spring Grove State Hospital*  
How long in hospital or institution? *19 years, 9 months*

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State *Maryland* County \_\_\_\_\_  
City or town *Baltimore*  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. *718 Belgian Avenue*  
(If rural, give LOCATION)  
2. (a) If veteran, name war \_\_\_\_\_ ✓

## 3. (a) FULL NAME

*William H. Hilton*

## 3. (b) Social Security Number

4. Sex *male* 5. Color or race *white* 6. (a) Single, married, widowed, or divorced *married*  
6. (b) Name of husband or wife *Mollie E. Ritter*  
6. (c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) *December 22, 1863*  
8. AGE: Years *84* Months *11* Days *23* If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace *St. Mary's Co., Maryland*  
(Town, county, and state)  
10. Usual occupation *Farmer*  
11. Industry or business *Farm*  
MOTHER FATHER  
12. Name *John Hilton*  
13. Birthplace *Maryland*  
14. Maiden name *Pamelia Bohanan*  
15. Birthplace *St. Mary's Co., Maryland*

16. Informant *Hospital records*  
Address *Catonsville-28, Maryland*  
17. *Burial* Date thereof *Dec. 17, 1948*  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory *St. John's*  
Location *Ruststown Md*  
18. Funeral director *J. F. Elmer Sons*  
Address *Ruststown Md*

19. *12-15* 19 *48* *W.E. Harry*  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH *December 15* 19 *48* at *3:20 am*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

\_\_\_\_\_ 19 \_\_\_\_\_ 10 \_\_\_\_\_ 19 \_\_\_\_\_

and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_

Immediate cause of death *Acute cardiac failure* DURATION \_\_\_\_\_Due to *Coronary vascular renal disease*

Due to \_\_\_\_\_

Other conditions *fracture of left femur*

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

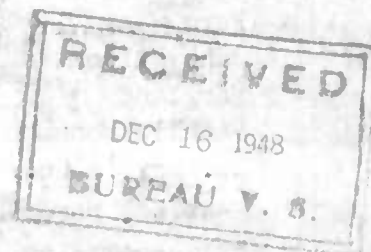
Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide *Accident* Date of *12-5-48*Where did injury occur? *Catonsville Hospital Baltimore* (City or town) (County) (State)Injured at home, term, industry, public place (where?) *hospital*Nature of injury *fallen from floor man* Injured at work? *no*23. SIGNATURE *Geo. L. M. Kieffer* *Exam of Baltimore*Address *1010 Leeds Ave* Date signed *12-15-48*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

12214

93d

Reg. Diet. No. 31

## 1. PLACE OF DEATH:

County BaltimoreCity or town Hollofield  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Baltimore 7  
(If outside city or town limits, write RURAL and give nearest town)Street No. Dogwood Road (Hollofield)  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Bessie Margaret Humphrey

## 3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

FWMarried6. (b) Name of husband or wife Charles H. Humphrey

8. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 12, 18818. AGE: Years Months Days If less than one day  
67 4 19 hrs. min.9. Birthplace Virginia  
(Town, county, and state)10. Usual occupation At Home

11. Industry or business

12. Name Daniel Hawes13. Birthplace Va14. Maiden name Unknown15. Birthplace Va16. Informant Charles H. HumphreyAddress Baltimore 7, Md.17. Burial Date thereof 1-3-49  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Good ShepherdLocation Ellicott City Md.18. Funeral director F. C. HiginbothamAddress Ellicott City Md.19. 1/1/48 1948 Wm. E. Martin  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 31 19 48 at 2:15 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Oct 19 48 to Dec. 31 19 48and that I last saw him alive on Dec. 30 19 48

Immediate cause of death

Chr. Valv. Heart Diseasebroken compensation

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. E. Martin M. D. or otherAddress Pandalltown Date signed 1/1/48

RECEIVED

JAN 4 1949

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 31

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Floral Park nr. Woodlawn  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 33 Yrs.  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore  
 City or town Floral Park nr. Woodlawn  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1628 Ingleside Ave.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Mary M. Jackson

## 3. (b) Social Security Number

none

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Mr. Leo Jackson  
 7. Birth date of deceased (mo., day, yr.) July 29, 1891  
 8. AGE: Years 57 Months 5 Days 0 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Baltimore, Md.  
 (Town, county, and state)  
 10. Usual occupation Housewife  
 11. Industry or business \_\_\_\_\_

12. Name John Steinmetz  
 13. Birthplace Baltimore, Md.  
 14. Maiden name Anna Lechel  
 15. Birthplace Baltimore, Md.

16. Informant Mr. Leo Jackson  
1628 Ingleside Ave.,  
 Address \_\_\_\_\_

17. Burial Date thereof Jan. 1, 1949  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Woodlawn  
 Location Woodlawn, Md.

18. Funeral director G. Howard Strong  
 Address 3207 W. North Ave.,

19. Dec. 31 1948  
 (Date rec'd by registrar) G.W. Hedrick Registrar

## MEDICAL CERTIFICATION

8.30

20. DATE OF DEATH December 29, 1948, at p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 17 1948, to Dec 29 1948, and that I last saw her alive on Dec 28 1948.

Immediate cause of death Coronary occlusion DURATION about 2 hrs.  
 Due to Cardiovascular disease about 2 yrs.

Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Thaler Dubitt M. D. or other \_\_\_\_\_  
 Address 2220 Garrison Blvd Date signed Dec 30

MARGIN RESERVED FOR BINDING

VS-A15

9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## 1. PLACE OF DEATH:

(a) Baltimore City, Maryland  
(b) Street address Bellona & Gittings  
(c) Hospital or institution:

Mercy Villa

(d) Length of stay in hospital or inst. (yrs., mos., or days).....

(e) Length of stay in Baltimore (yrs., mos., or days).....

## 2. USUAL RESIDENCE OF DECEASED:

Md.  
(a) State..... (b) County.....  
(c) City or town Baltimore  
(If outside city or town limits, write RURAL and give town)  
1724 Linden Ave.  
(d) Street No..... (If rural give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

## 3 (a) FULL NAME

MARY F. JENKINS3 (b) If veteran, name war  
no3 (c) Social Security Account  
No. no

4. Sex female 5. Color or race white 6 (a) Single, married, widowed, or divorced. widow

6 (b) Name of husband or wife Eugene Jenkins  
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 23, 1863

8. AGE: Years 85 Months 8 Days 19 If less than one day  
hr. min.

9. Birthplace Baltimore, Md.  
(Town, county, and state)

10. Usual Occupation Retired housewife

11. Industry or business

12. Name Michael M. Frederick13. Birthplace Germany14. Maiden Name Anna15. Birthplace Germany16 (a) Informant Mr. B. J. Frederick(b) Address 115 W. Saratoga St.

17 (a) Burial (b) Date thereof 12/15/48  
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Cathedral Cem.  
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS(b) Address Baltimore, Md.

19 (a) 12/14/48 (b) A. W. Medsker  
(Date of registration) (Signature)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 12, 1948 at 6:45pm

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 20, 1948 to Dec. 12, 1948, and that I last saw her alive on 12-12-1948.

Immediate cause of death Hypertension Duration 2 yrs

Due to Cerebral Hemorrhage 3 weeks

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature P. B. Flynn M. D.Address 112 Chen St. Date signed 12-13-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

12217

## 1. PLACE OF DEATH:

County.....Balto.  
 City or town.....Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

Opitz Home

How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Md. County.....  
 City or town.....Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....1918 Sulgrave Ave.  
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

IDA V. JONES

## 3. (b) Social Security Number

none

4. Sex.....female  
 5. Color or race.....white  
 6.(a) Single, married, widowed, or divorced.....single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.).....June 22, 1859  
 6.(c) If alive, give age.....years

8. AGE: Years.....89 Months.....6 Days.....0  
 It less than one day.....hrs. ....min.

9. Birthplace.....Baltimore, Md.  
 (Town, county, and state)  
None

10. Usual occupation.....

11. Industry or business.....

12. Name.....Stephen W. Jones13. Birthplace.....Baltimore, Md.14. Maiden name.....Susan M. Carter15. Birthplace.....Baltimore, Md.16. Informant.....Mrs. Nellie HoskinsAddress.....3405 University Place

17. Burial.....12/24/48  
 (Burial, cremation, or removal. Which?).....(month) (day) (year)

Cemetery or crematory.....Greenmount Cem.Location.....Balto., Md.18. Funeral director.....WM. J. TICKNER & SONSAddress.....Balto., Md.

19. Dec 24 1948 R.M.B.  
 (Date rec'd by registrar) Registrar.....W. H. H. H. H.

## MEDICAL CERTIFICATION

Dec. 22, 48 4:15 p

20. DATE OF DEATH.....19.....at.....

21. CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 19 48 to Dec 22 48  
 and that I last saw him alive on Dec 22 48

Immediate cause of death.....

Cerebral Hemorrhage  
2 days

Due to.....Arteriosclerosis

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur?.....(City of town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury..... Injured at work? .....

23. SIGNATURE.....W. H. H. H. H. M. D. or other

Address.....Catonsville Date signed 12/23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

12218

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 10 years, 4 months, 28 days  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution? 10 years, 4 months, 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County \_\_\_\_\_  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 420 South Payson Street  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Anna Kalmer

## 3. (b) Social Security Number

## 4. Sex

female

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

widowed

## 6. (b) Name of husband or wife

Philip Kahmer

## 7. Birth date of deceased (mo., day, yr.)

April 4, 1872

## 6. (c) If alive, give age \_\_\_\_\_ years

## 8. AGE:

Years

Months

Days

If less than one day

76

8

25

hrs.

min.

## 9. Birthplace

Maryland  
(Town, county, and state)

## 10. Usual occupation

Housewife

## 11. Industry or business

Home

## MOTHER FATHER

## 12. Name

Charles Brown

## 13. Birthplace

Maryland

## 14. Maiden name

Sophie Meyers

## 15. Birthplace

Maryland

## 16. Informant

Hospital records

## Address

Catonsville-28, Maryland

## 17.

(Burial, cremation, or removal, which?)

Date thereof

Jan 1-49  
(month) (day) (year)

## Cemetery or crematory

London Park

## Location

Balto. 28. Ind.

## 18. Funeral director

F. B. Wepfer &amp; Son

## Address

1300 Center Place

## 19.

1-1-49  
(Date rec'd by registrar)

19.

V.E. Harris

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 29 19 48 at 8:22 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 1 19 38 to December 29 19 48and that I last saw him er alive on December 29 19 48

Immediate cause of death

Pulmonary oedema

DURATION

6 hours

Due to

Cardiac failure

3 days

Due to

Arteriosclerotic cardiovascular disease

indefinite

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Isadora Tuerk, M.D.

M. D. or other

Address

Catonsville-28, Md.

Date signed 12-29-49

RECEIVED

JAN 4 1949

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 41

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For persons born in this State give residence of mother)

State Md County Baltimore  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3112 O'Donnell St  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

MARION LOUIS KARWACKI

## 3. (b) Social Security Number

4. Sex

M

5. Color or race

Wh.

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Margaret Karwacki

7. Birth date of deceased (mo., day, yr.)

Oct. 19 1921

8. AGE:

Years

Months

Days

If less than one day

27

hrs.

min.

9. Birthplace

Balto

(Town, county, and state)

10. Usual occupation

Chauffeur

11. Industry or business

Standard Oil

FATHER

12. Name

John Karwacki

MOTHER

13. Birthplace

Poland

14. Maiden name

Michaelina

15. Birthplace

Poland

16. Informant

Mrs Margaret Karwacki

Address

3112 O'Donnell St.

17.

Burial

Date thereof

12/20/48

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Sacred Heart of Mary

Location

German Hill R.O.D.

18. Funeral director

Stephen J. Fialkowski INC

Address

1000 S. Kennerly

19.

Dec 20 19 48a w. H. H. H.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec. 15

19

48 at 5:30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Gravid Occlusion

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. Davis M.D.

Address

Date signed 12/16/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

12220

Reg. Diat. No.

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Pikesville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 1/2 yrs.  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Baltimore  
 City or town Pikesville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 213 Church Lane  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Mary Helen Kennedy

## 3. (b) Social Security Number

none

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 22 June 1911  
 6.(c) If alive, give age \_\_\_\_\_ years

8. AGE: Years Months Days If less than one day

3755hrs. min.9. Birthplace Pikesville, Maryland  
(Town, county, and state)10. Usual occupation none

11. Industry or business

FATHER

12. Name Joseph A. Kennedy13. Birthplace Maryland

MOTHER

14. Maiden name Mary C. Dwyer15. Birthplace Maryland16. Informant Joseph A. Kennedy  
Address 213 Church Lane Pikesville, Md17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof 12/4/48  
(month) (day) (year)Cemetery or crematory St. Charles French RdLocation Pikesville, Md18. Funeral director Frank H. NewellAddress Pikesville, Md19. 12-3- 1948 E. B. Michaels  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2 Dec 19 48 at 10 45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 19 46 to 1 Dec 19 48and that I last saw h. sr. alive on 1 Dec 19 48

Immediate cause of death

Cardiorespiratory failure

DURATION

Due to

Epilepsy20 yrs

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations noneDate of op. —Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, pub'c place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE

Paul H. Royse M.D.

M. D. or other

Address Pikesville 8 Rd Date signed 1 Dec 48



RECEIVED

DEC 6 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. *12221*

### 1. PLACE OF DEATH:

County *BALTIMORE*  
City or town *MIDDLE RIVER*  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? *7 YRS*  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *MARYLAND* County *BALTIMORE*  
City or town *MIDDLE RIVER MD*  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. *1405 WILSON POINT RD*  
(If rural, give LOCATION)  
2. (a) If veteran, name war

### 3. (a) FULL NAME

*FRANK KIEFNER*

### 3. (b) Social Security Number

*NONE*

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

*MALE WHITE WIDOWED*

6. (b) Name of husband or wife *MINNIE KIEFNER*

7. Birth date of deceased (mo., day, yr.) *APRIL 29, 1868* 6. (c) If alive, give age years

8. AGE: Years Months Days If less than one day  
*80 7 26* hrs. min.

9. Birthplace *MARYLAND*  
(Town, county, and state)

10. Usual occupation *RETIRED CARPENTER*

11. Industry or business

12. Name *UNKNOWN*

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant *CATHERINE NIELSON*

Address *1405 WILSON POINT RD*

17. *BURIAL* Date thereof *12-29-48*  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *MT. CARMEL CEM*

Location *O'DONNELL ST.*

19. Funeral director *Joseph J. Ambrose Jr*

Address *1328 Sulphur Spring Rd*

19. *12/28* 19 *48* *U.W. Hedrich*  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH *DECEMBER 25* 19 *48*, at *6:30 A.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*- out 2* 19 *48* to *Dec 25* 19 *48*  
and that I last saw him alive on *Dec 20* 19 *48*

Immediate cause of death *- Chronic Endocarditis*

DURATION

*4 mos.*

Due to *- General Anoxia*

*4 mos.*

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results *None*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE *O.B. Whetstone MD*

M. D. or other

Address *1279 Guilham St* Date signed *12/27/48*

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of items # 7 & 8, and addition of items # 12, 13, 14 & 15 shown on: 2411 N. Charles St., Baltimore

**MARYLAND STATE DEPARTMENT OF HEALTH**

**CERTIFICATE OF DEATH**

12222

Reg. Dist. No. 44

**1. PLACE OF DEATH:**

County Baltimore  
 City or town Fort Howard  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 Day  
 Hospital, institution, or street address where death occurred:  
Vets. Adm. Hospital, Ft. Howard, Md.  
 How long in hospital or institution? 1 Day

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)  
 State Maryland County Rest  
 City or town Rock Hall  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. none  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war WW-I

**3. (a) FULL NAME**

BERNARD F. KILLION

**3. (b) Social Security Number**

204-05-1879

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single  
 6. (b) Name of husband or wife Single  
 7. Birth date of deceased (mo., day, yr.) Oct. 16, 1879  
 6. (c) If alive, give age 18 years  
 8. AGE: Years 65 Months 6 Days 2 If less than one day 68 hrs. 68 min.

9. Birthplace Philadelphia, Pa.  
 (Town, county, and state)  
 10. Usual occupation Unemployed  
 11. Industry or business  
 12. Name Bernard F. Killion, Sr.  
 13. Birthplace Philadelphia, Pa.  
 14. Maiden name Mary E. Starr  
 15. Birthplace New Orleans

16. Informant Clinical Records, Vets. Adm. Hosp.  
 Address Fort Howard, Md.

17. Removal Date thereof 12/23/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Philadelpia, Pa. (Mr. Logan Funeral Home)  
 Location Blight Funeral Home  
 18. Funeral director Blight Funeral Home  
 Address 6009 Harford Rd., Baltimore, Md.

19. 12/23 19 48 a. w. Hafmark  
 (Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH December 22, 1948 at 2:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 21, 1948 to December 22, 1948  
 and that I last saw him alive on December 22, 1948

Immediate cause of death CEREBRAL HEMORRHAGE DURATION Unknown

Due to HYPERTENSION, ESSENTIAL Unknown

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, pub'c place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul Padget

PAUL PADGET, M. D., ACTING CHIEF PRO. SER.

Address VAH, FORT HOWARD, MD. Date signed 12-22-48

MARGIN RESERVED FOR BINDING

9-45-18

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH: *Balto.*  
 County.....*6408 Walnut Ave*  
 City or town.....*Waldman*  
 (If outside city or town limits, write RURAL and give nearest town)  
 Now long in above place of death?.....*Life*  
 Hospital, institution, or street address where death occurred:

Now long in hospital or institution?

3. (a) FULL NAME

*Meretta E. Koenig*

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

*Female white single*

6. (b) Name of husband or wife

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

*July 11, 1882*

8. AGE:

*66*

Months

*9*

Days

*22*

If less than one day

hrs.

min.

9. Birthplace

*Balto.*

(Town, county, and state)

10. Usual occupation

*Retired Teacher*

11. Industry or business

MOTHER

FATHER

12. Name

*Henry A. Koenig*

13. Birthplace

*Curwens*

14. Maiden name

*Elizabeth Koenig*

15. Birthplace

*Balto.*

16. Informant

*Edith W. Mills*

Address

*6408 Walnut Ave*

17.

(Burial, cremation, or removal, Which?)

Date thereof

*Dec. 6, 48*

(month) (day) (year)

Cemetery or crematory

*London Park*

Location

*2801 Frederick Ave*

18. Funeral director

*John O. Mitchell Sons*

Address

*1800 Eutaw Place*

19.

(Date rec'd by registrar)

*12/6*

19

*48**2 W. H. H. H.*

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

*Md*

County

*Balto.*

City or town

*Waldman*

(If outside city or town limits, write RURAL and give nearest town)

Street No.

*6408 Walnut Ave*

(If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH

*Dec. 3*

19

*48* at *1 A* M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*March 1*

19

*48*, to*Dec 3*

19

*48*and that I last saw *her* alive on*Dec. 3*

19

*48*

Immediate cause of death

*Coronary Thrombosis*

DURATION

*3 hrs*

Due to

*Generalized Atherosclerosis*

Due to

*Chronic Myocardial Deg. 1 yr*

Other conditions

*Chronic Hypertensive Pathosis 20 yrs*

(Include pregnancy within 8 months of death)

Major findings of operations

*No operation*

Date of op.

Autopsy results

*No autopsy*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

*Joshua H. Amusecost M.D.*

M. D. or other

Address

*6419 Windsor Hill Rd*

Signed

*12/3/48**Baltimore - 7 Md*

MARGIN RESERVED FOR BINDING

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12223

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

12224

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? One month  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution? One month

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County \_\_\_\_\_  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 311 S. Castle Street  
 (If rural, give LOCATION)  
 2(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

JOSEPH KOWNACKI

## 3. (b) Social Security Number

215-05-3281

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Josephine Kownacki  
 6. (c) If alive, give age 54 years  
 7. Birth date of deceased (mo., day, yr.) November 1, 1894  
 8. AGE: Years 54 Months 1 Days 16 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Poland  
 (Town, county, and state)  
 10. Usual occupation Longshoreman  
 11. Industry or business Laborer  
 12. Name John Kownacki  
 13. Birthplace Poland  
 14. Maiden name Josephine (unknown)  
 15. Birthplace Poland

16. Informant Hospital records  
 Address Catonsville 28, Md.

17. Burial Date thereof Dec 21 1948  
 (Burial, cremation, or removal, which?) (month) (day) (year)  
 Cemetery or crematory Holy Rosary Chm  
 Location Balto County  
 18. Funeral director John M. Weber  
 Address 401 S. Chester Street  
 19. Dec 20 48 Registrar W. H. H. H.  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 17, 1948 at 12:35a.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 17, 1948 to December 17, 1948and that I last saw him alive on December 17, 1948Immediate cause of death  
Uremia, chronicDURATION  
IndefiniteDue to Congenital polycystic kidney disease bilateralLifeDue to Hypertensive cardiovascular diseaseIndefiniteOther conditions Carbuncle of leg1 week

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Isadore Tuerk, M.D.

M. D. or other

Address Catonsville 28, Md. Date signed 12/17/48



BALTIMORE CITY HEALTH DEPARTMENT  
 CERTIFICATE OF DEATH

Registered No. 93d

1. PLACE OF DEATH: Co  
 (a) Baltimore City Maryland  
 (b) Street address 1915 Snyder ave  
 (c) Hospital or institution:  
 (d) Length of stay in hospital or inst. (yrs., mos., or days)  
 (e) Length of stay in Baltimore (yrs., mos., or days) 20

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Ind. (b) County Baltimore  
 (c) City or town Baltimore Co.  
 (If outside city or town limits, write RURAL and give town)  
 (d) Street No. 1915 Snyder ave  
 (If rural give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country

3 (a) FULL NAME Stanislaw Krakowiak  
 3 (b) If veteran, name war  
 3 (c) Social Security Account No. 213-07-2492

4. Sex M 5. Color or race W 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Katemia Krakowiak  
 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years 56 Months Days If less than one day hr. min.

9. Birthplace Poland  
 (Town, county, and state)

10. Usual Occupation Labor

11. Industry or business

FATHER 12. Name Paul Krakowiak

13. Birthplace Poland

MOTHER 14. Maiden Name Unknown

15. Birthplace Poland

16 (a) Informant Mrs. Katemia Krakowiak

(b) Address 1915 Snyder ave

17 (a) Burial (b) Date thereof Dec 4, 1948  
 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Rosary Cem  
 Location Balto. County

18 (a) Funeral director John M. Weber

(b) Address 401 S. Chester Street

19 (a) DEC 3 - 1948 (b) Huntington National Bank  
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 1 1948 at A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 12 1947 to Dec 1 1948, and that I last saw him alive on Nov 30 1948.

Immediate cause of death Congestive Heart Failure

Due to Coronary Artery Disease Duration 1 Mo

Due to Hypertension C. V. Disease 2 yrs.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide.

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury MACROVIAK

23. Signature Stephan C. Mackowiak

Address 6714 Holmdel Ave Date signed 12/5/48

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

12226

Reg. Dist. No. 32

## 1. PLACE OF DEATH:

County..... Baltimore  
 City or town..... Pikesville  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
Augsburg Home

How long in hospital or institution? 5 Yrs.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md. County..... Baltimore  
 City or town..... Pikesville  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. Campfield Rd.  
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Catherine Kruspe

## 3. (b) Social Security Number

4. Sex..... F 5. Color or race..... W 6. (a) Single, married, widowed, or divorced..... Widow  
 6. (b) Name of husband or wife..... Gustav  
 8. (c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.) Dec. 20, 1857  
 8. AGE: Years..... 90 Months..... Days..... It less than one day..... hrs. .... min.

9. Birthplace..... Reading Pa.  
 (Town, county, and state)

10. Usual occupation..... None

11. Industry or business.....

MOTHER FATHER  
 12. Name..... David Henzler  
 13. Birthplace..... Germany  
 14. Maiden name..... Mary ?  
 15. Birthplace..... Germany

16. Informant..... Records Augsburg Home  
 Address..... Campfield Rd.

17. Burial Date thereof..... Dec. 13, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... North Cedar Hill Cem.  
 Location..... Philadelphia Pa.

18. Funeral director..... L. Heermann and Son  
 Address..... 6067 Harford Rd.

19. 12-11-1948 Dr. E. E. Nichols  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... December 10 1948 at 9:45 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
March - 10 1947 to Dec. 10 1948  
 and that I last saw her alive on Dec. 9th 1948

Immediate cause of death.....  
Arteriosclerosis - Cardiovascular Disease -  
Generalized Arteriosclerosis -  
Sclerotic Disease

## DURATION

7 yrs.

Due to.....  
 Due to.....

Other conditions.....  
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op. ....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of .....  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE..... Carl L. Chambers M. D. or other  
 Address..... 4108 Liberty St. Date signed..... 12/11/48

RECEIVED

DEC 13 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 12227 44

1. PLACE OF DEATH  
 County Balto.  
 City or town Essex  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
420 Oriole Ave.  
 How long in hospital or institution? 6 mrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Same County Same  
 City or town Same  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Same  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war Same

## 3. (a) FULL NAME

John Kucharczyk  
 4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of ~~husband~~ wife Martha

## 3. (b) Social Security Number

215-09-7192

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 1, 48 at 1:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 19 40 19and that I last saw him alive on 19 40 19Immediate cause of death Coronary occlusionDue to HypertensionDue to SameOther conditions SameMajor findings of operations SameAutopsy results Same

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Same Date of SameWhere did injury occur? Same (City or town) (County) (State)Injured at home, farm, industry, public place (where?) SameMeans of injury Same Injured at work? Same23. SIGNATURE Montgomery, Md.Address Balto Co. Dental7. Birth date of deceased (mo., day, yr.) Oct 12/18968. AGE: 52 Years 1 Months 19 Days 19 hrs. 19 min.9. Birthplace Poland  
(Town, county, and state)10. Usual occupation Fireman11. Industry or business Iron, Coal & Steel12. Name Antoni Kucharczyk13. Birthplace Poland14. Maiden name Frances Reputakowski15. Birthplace Poland16. Informant Mrs. Martha KucharczykAddress 420 Oriole Ave17. Burial Date thereof 12-4-48

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery Holy RosaryLocation Baltimore County Md.18. Funeral director George A. WeberAddress 705 South Ann Street19. Dec 2 19 48 A. W. Hedrich

(Date rec'd by registrar) Registrar

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

12228

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Rural - Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 9 1/2 years  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution? .....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.  
 City or town Towson  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 327 Dixie Drive  
 (If rural, give LOCATION)

2.(a) If veteran, name war .....

## 3. (a) FULL NAME

William Henry Lutz

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Mabel Dyer Lutz  
July 3, 1886 6. (c) If alive, give age 62 years  
 7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 62 Months 5 Days 21 If less than one day  
 hrs. min.

9. Birthplace Baltimore, Maryland  
 (Town, county, and state)

10. Usual occupation Insurance Business11. Industry or business St Paul Fire & Marine12. Name William Henry Lutz13. Birthplace Maryland14. Maiden name Mary Anne Kneaf15. Birthplace Pennsylvania16. Informant Wm Mabel Dyer LutzAddress 327 Dixie Drive, Towson

17. Burial Date thereof Dec 28, 1948  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or ossuary Landon Park Cem.Location End Ave. Balto. Md.18. Funeral director John O. Mitchell SonsAddress 1900 Eutaw Place

19. 12-27 19 48 G.W. Kelsch  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 24 19 48 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 29 19 48 to December 24 19 48  
 and that I last saw him alive on December 14 19 48

Immediate cause of death Arteriosclerotic Heart Disease DURATION 3 1/2 years

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 8 months of death)

Major findings of operations .....

Date of op. ....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide .....

Date of .....

Where did injury occur? .....

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury .....

Injured at work?

23. SIGNATURE W. Grafton Hespergen M. D. or other

214 Medical Art Bldg. Date signed 12/24/48  
 Address .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 31

12229

93d

## 1. PLACE OF DEATH:

County BaltimoreCity or town Villa Nova  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 yrs.Hospital, institution, or street address where death occurred:  
Catherine Robb Nursing HomeHow long in hospital or institution? 4 yrs

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Rockdale  
(If outside city or town limits, write RURAL and give nearest town)Street No. 3621 Milford Mill Road  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Barbara D. Lauterbach

## 3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
<u>Female</u>	<u>White</u>	<u>Single</u>

6. (b) Name of husband or wife

B. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 4, 1861

8. AGE:	Years	Months	Days	If less than one day
	<u>87</u>	<u>9</u>	<u>3</u>	hrs. min.

9. Birthplace Maryland  
(Town, county, and state)10. Usual occupation None

11. Industry or business

12. Name Henry Lauterbach13. Birthplace Germany14. Maiden name Unknown15. Birthplace Germany16. Informant Mrs. James H. WheatleyAddress 3621 Milford Mill Road17. Burial Date thereof Dec. 9, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Messiah Lutheran Cem.Location Carroll Co., Md.18. Funeral director C. Harry WeerAddress Sykesville, Md.19. 12/7/48 19 48 Wm. E. Martin  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 7 19 48 at 2:15 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1944 to Dec. 7 19 48  
and that I last saw her alive on Dec. 7 19 48

Immediate cause of death

Cardiovascular Disease

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. E. Martin M. D. or otherAddress Randallstown Date signed 12/7/48

RECEIVED

JAN 4 1949

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 12230  
32

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Dwight Mills  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 6 yrs  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Baltimore  
 City or town Dwight Mills  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Acriston Rd  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

MARGARET LEHMAN

## 3. (b) Social Security Number

4. Sex F. 5. Color or race W. 6.(a) Single, married, widowed, or divorced Widow  
 6.(b) Name of husband or wife Anthony Lehman  
Deceased 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) April 19 - 1857  
 8. AGE: Years 91 Months 7 Days 18 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Germany  
(Town, county, and state)10. Usual occupation Housework

11. Industry or business

12. Name Ferdinand Wick13. Birthplace Germany14. Maiden name Friederika Wick15. Birthplace Germany16. Informant Anthony LehmannAddress Dwight Mills, Maryland17. (Burial, cremation, or removal, Which?) Burial Date thereof Dec 8, 1948  
(month) (day) (year)Cemetery or crematory London ParkLocation Friedrich Rd. Balt. Md16. Funeral director Frank H. NeurellAddress Pikesville, Maryland19. 12 - 7 - 1948 Dr E E Nichols  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec - 6 19 48 at 3 A. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1 19 48 to Dec 6 19 48and that I last saw him alive on Dec 5 19 48Immediate cause of death Arterio Sclerosis DURATION —Due to —Due to —Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —Where did injury occur? — (City or town) (County) (State)Injured at home, farm, industry, public place (where?) —Means of injury — Injured at work? —23. SIGNATURE E E Nichols M. D. or otherAddress Pikesville 8. Md. Date signed 12 - 7 - 48

UNITED STATES DEPARTMENT OF JUSTICE

CLASSIFICATION OF DOCUMENT

CONFIDENTIAL  
EXCLUDED FROM AUTOMATIC  
DECLASSIFICATION  
DATE 10-10-2000  
BY 1043

MARKET LEADER

RECEIVED  
DEC 10 1948  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

12231

## 1. PLACE OF DEATH

County BaltimoreCity or town Midstate River  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For new born infants give residence of mother)

State Md County BaltimoreCity or town Baltimore  
(If outside city or town limits write RURAL and give nearest town)Street No. 1127 E. Balt. St.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Stanley Thomas Lucas

## 3. (b) Social Security Number

## 4. Sex

M

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Child

## 6. (b) Name of husband or wife

Infant

## 7. Birth date of

deceased (mo., day, yr.)

Dec. 15 - 1948

6. (c) If alive, give age years

## 8. AGE:

Years

Months

Days

It less than one day

0013

hrs.

min.

## 9. Birthplace

Baltimore, Md.

(Town, county, and state)

## 10. Usual occupation

Child

## 11. Industry or business

Allen Lucas

## FATHER

## 12. Name

## 13. Birthplace

(?)

## MOTHER

## 14. Maiden name

(?)

## 15. Birthplace

## 16. Informant

Mr. Allen Lucas

## Address

1127 E. Baltimore St.

## 17. (Burial, cremation, or removal. Which?)

Burial

Date thereof

Jan. 3, 1949

(month) (day) (year)

## Cemetery or crematory

St. Peters Cemetery

## Location

City

## 18. Funeral director

WIEDEFELD & SON

## Address

GREENMOUNT AVE & 22ND

## 19. (Date rec'd by registrar)

1/13

19

x9Ad. Hedrick

Registrar

## 23. SIGNATURE

W. B. Davis M.D.  
Address Baltimore, Md. Date signed 1/30/49

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

Dec. 181948

at

9:30 A.M.

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1948 to 1948and that I last saw him alive on 1948

## Immediate cause of death

Hydrocephalus

## Due to

congenital

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op. ?

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Usual Date of ?Where did injury occur? Usual (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

## Means of injury

Injured at work?

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

95C

12232

Reg. Dist. No. 38

## 1. PLACE OF DEATH

County BaltimoreCity or town Towson  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Charles Madden

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Amanda

7. Birth date of deceased (mo., day, yr.)

July 1874

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

44

hrs.

min.

9. Birthplace

Reisterstown Md.

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

FATHER

12. Name

Alfred Madden

13. Birthplace

MD

14. Maiden name

&amp;

15. Birthplace

&amp;

16. Informant

Bessie Bess

Address

Cromwell Bridge Rd Towson Md

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof

12-31-1948

Cemetery or crematory

Pleasant Rest. Towson Md

Location

Baltimore

18. Funeral director

Borowitman & Knight

Address

721 E. Baltimore St Baltimore, Md

19.

(Date received by registrar)

12/30/48A. W. Gehring

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED

(For newborn infants give residence of mother)

State

Maryland

County

Baltimore

City or town

Towson

(If outside city or town limits, write RURAL and give nearest town)

Street No.

North York Road

(If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH

December 27 1948at 6:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

None 19..... to..... 19.....

and that I last saw him..... live on..... 19.....

Immediate cause of death

Chronic heart disease coming with

Due to

Due to

Other conditions

Smile changes with activities

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Rollin C. Hudson M.D.

M. D. or other

Address

Towson Md

Date signed

12/27/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville 28, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 11 yrs., 0 mos., 18 das.  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution? 11 yrs., 0 mos., 18 das.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel  
 City or town Deale  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

George Edward Mason

## 3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married  
 6.(b) Name of husband or wife Mrs. Florence Mason  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) March 13, 1871  
 8. AGE: Years 77 Months 77 Days 8 If less than one day 25 hrs. 25 min.

9. Birthplace Deale, Anne Arundel County, Maryland  
 (Town, county, and state)  
 10. Usual occupation Waterman

11. Industry or business Laborer

MOTHER FATHER  
 12. Name Edward Mason  
 13. Birthplace Virginia

14. Maiden name May Daugherty  
 15. Birthplace Maryland

16. Informant Hospital Records  
 Address Catonsville 28, Maryland

17. Buried Date thereof 12-11-48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory St James  
 Location Trappe Md  
 18. Funeral director T. H. Hardisty & Son  
 Address Melville Rd

19. 12-9 19 48 V.E. Harvey  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 8, 1948 at 8:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
August 19, 1936 to December 8, 1948  
 and that I last saw him alive on December 8, 1948

Immediate cause of death Arteriosclerotic heart disease DURATION years

Due to Arteriosclerosis, generalized " "

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury Broken Jug Injured at work? \_\_\_\_\_

23. SIGNATURE Isadore Tuerk, M.D. M. D. or other

Catonsville-28, Md. Address 12-9-48 Date signed



RECEIVED  
DEC 11 1943  
BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. XX

12234

## 1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 53 days

Hospital, institution, or street address where death occurred:

Vet. Adm. Hospital, Ft. Howard, Md.How long in hospital or institution? 53 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County \_\_\_\_\_City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 642 West Fayette Street  
(If rural, give LOCATION)2. (a) If veteran, name war WW I

## 3. (a) FULL NAME

CHARLES M. MATHENA

## 3. (b) Social Security Number

217-17-1838

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MALEWHITEMARRIED6. (b) Name of husband or wife Mrs. Virginia Mathena6. (c) If alive, give age 25 years7. Birth date of deceased (mo., day, yr.) July 28, 18978. AGE: Years Months Days If less than one day  
51 4 26 \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Princeton, West Virginia  
(Town, county, and state)10. Usual occupation Painter

11. Industry or business

FATHER 12. Name Parris Mathena13. Birthplace West VirginiaMOTHER 14. Maiden name Laura Bolden15. Birthplace West Virginia16. Informant Clinical Records, Vets. Adm. Hosp.Address Fort Howard, Maryland17. Burial Removal Date thereof 12 27 48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory \_\_\_\_\_

Location PRINCETON, W.VA. (FREDERICK & SEEVER FUNERAL-HOME)18. Funeral director Howard H. BlightAddress 6009 Harford Road19. 12 27 48 D.W. Redick  
(Date rec'd by registrar) (Signature) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 24 19 48 at 12:35 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 1, 19 48 to December 24 19 48and that I last saw him alive on December 24 19 48Immediate cause of death CARCINOMA OF STOMACH  
WITH METASTASES DURATION 4 mos.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results /Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Charles Shaw M. D. or otherAddress VAH, Fort Howard, Md. Date signed \_\_\_\_\_

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

12235

Reg. Dist. No. 33

### 1. PLACE OF DEATH:

County Baltimore  
City or town Reisterstown  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 15 yrs  
Hospital, institution, or street address where death occurred:  
  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore  
City or town Reisterstown  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Berrymans Lane  
(If rural, give LOCATION)  
2.(a) If veteran, name war.

### 3. (a) FULL NAME

Edgar W. Meese

### 3. (b) Social Security Number

097-16-7212

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Widowed</u>
6. (b) Name of husband or wife <u>Clara Arnold</u>		
7. Birth date of deceased (mo., day, yr.) <u>Feb. 13, 1880</u>		
6. (c) If alive, give age _____ years		
8. AGE: Years <u>68</u>	Months <u>10</u>	Days <u>13</u> hrs. _____ min.

9. Birthplace Harrisburg Penna.  
(Town, county, and state)

10. Usual occupation Manager of Theatre

### 11. Industry or business

12. Name Jacob Meese  
13. Birthplace Penna.

14. Maiden name Anna Sayford  
15. Birthplace Penna.

16. Informant Mrs. C. H. Kahl  
Address Reisterstown, Md.

17. Burial Dec. 29, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory All-Saints  
Location Reisterstown, Md.

18. Funeral director J. F. Eline, Sons  
Address Reisterstown, Md.

19. 12-28- 1948 Mary B. Eline.  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH December 26 1948, at 10 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-1-46 1946, to 12-26-48 1948

and that I last saw him alive on 12-16-48 1948

Immediate cause of death Angina Pectoris DURATION 2 yrs.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions arteriosclerosis 3 yrs.

(Include pregnancy within 3 months of death)

Major findings of operation None Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? None (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE D. D. Caples, M.D. M. D. or other  
Address Reisterstown, Md. Date signed 12-27-48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JAN 3 1949  
BUREAU T. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

## 1. PLACE OF DEATH:

County... Balto.

City or town... Brighton  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:  
Mt. Vernon Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md. County... Baltimore

City or town... Brighton  
(If outside city or town limits, write RURAL and give nearest town)Street No... Mt. Vernon Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war...

## 3. (a) FULL NAME

SUSAN A. MERRICK

## 3. (b) Social Security Number

none

4. Sex

female

5. Color or race

white

6.(a) Single, married, widowed, or divorced

none

6.(b) Name of husband or wife

Robert H. Merrick

7. Birth date of  
deceased (mo., day, yr.)

Dec. 2, 1866

6.(c) If alive, give age... years

8. AGE:

Years

Months

Days

If less than one day

82

0

28

hrs.

min.

9. Birthplace... Baltimore Co., Md.

(Town, county, and state)

10. Usual occupation...

none

11. Industry or business

FATHER

12. Name

John Slining

13. Birthplace

Md.

MOTHER

14. Maiden name

Barbara ?

15. Birthplace

Md.

16. Informant... Mrs. Joseph L. Krainer

Address... 401 Reisterstown Rd. Pikesville 8

17. Burial

Date thereof... 1/3/49

(Burial, cremation, or removal, Which?)

(month) (day) (year)

Cemetery or crematory

Druid Ridge Cem.

Location

Pikesville, Md.

18. Funeral director

WM. J. TICKNER &amp; SONS

Address

Balto., Md.

19. 1/3 19 49  
(Date filed by registrar)

19 49

O. W. Hedlund  
3m Registrar

SIGNATURE

Address... 7201 York Rd. Date signed... 1-3-49

## MEDICAL CERTIFICATION

20. DATE OF DEATH... Dec. 30, 19 48, at... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1946 to Dec 30 1948  
and that I last saw h... alive on 12-21-48 19

Immediate cause of death

1 Arterio Sclerosis

DURATION

unknown

Due to 1 Senility

3 years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

12237

38

1. PLACE OF DEATH: Baltimore  
County Baltimore  
City or town Baynesville (Towson 4)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
Goetze Avenue  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Md. County Balto.  
City or town Baynesville (Towson 4)  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Goetze Avenue  
(If rural, give LOCATION)  
2.(a) If veteran, name war

3. (a) FULL NAME

Mary Elizabeth Merryman

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow  
6.(b) Name of husband or wife John E. Merryman  
7. Birth date of deceased (mo., day, yr.) July 3, 1864  
8. AGE: Years 84 Months 5 Days 1 If less than one day  
hrs. min.

9. Birthplace Baltimore Co., Md.  
(Town, county, and state)  
10. Usual occupation Housewife  
11. Industry or business At Home  
12. Name William N. Lee  
13. Birthplace Md.  
14. Maiden name Elizabeth Coak  
15. Birthplace Md.

16. Informant Mrs. Wheatley  
Address Baynesville, Md.  
17. Burial Date thereof Dec. 7, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Prospect Hill Cemetery  
Location Towson, Md.  
18. Funeral director John Burnie's Son  
Address Towson, Md.  
19. Dec 7 19 48 a.w. Hynd  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH December 4, 1948 at 11:15 A. M.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 18 19 48 to Dec 3 19 48  
and that I last saw him alive on Dec 2 19 48  
Immediate cause of death Congestive heart failure DURATION 3 mos  
Due to arteriosclerosis ?  
Due to ?  
Other conditions arteriosclerosis ?  
(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....  
Autopsy results.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Date of.....  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?  
23. SIGNATURE Samuel A. H. H. H. M. D. or other  
Address 5611 Pauline St. Date signed.....

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 42

12238

## 1. PLACE OF DEATH:

County BaltimoreCity or town Burial: Arkatas Md  
(If outside city or town limits write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER  
MOTHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, where?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

19. 48, at 5:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

December 7 19. 48, to December 9 19. 48and that I last saw him alive on December 9 19. 48

Immediate cause of death

DURATION

Acute Coronary occlusionSudden

Due to

arteriosclerotic heart disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death due to violent cause, list in the following.

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 40

## 1. PLACE OF DEATH

County BaltimoreCity or town Fork  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

JAMES Hall - Milway

4. Sex

M.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

ROSE LORETTA DOYLE

7. Birth date of

deceased (mo., day, yr.)

Jan 4 - 1894

8. AGE:

Years

Months

Days

If less than one day

5411md

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

Assembly floor helperin machine shop

11. Industry or business

James Milway

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. Dec 12

1948

G. E. Arthur

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

219-106738

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec. 12 1948 at 2:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 12 1948 to 1948and that I last saw him alive on Dec 12 1948

Immediate cause of death

Fractured skull; due to auto accident

DURATION

12/12/48

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicideWhere did injury occur? Fork Baltimore MD

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) NoMeans of injury Auto turned over in front of NoInjured at work? No23. SIGNATURE Rollin G. Hudson MD P.M.E.Address Towson MdDate signed 12/12/48

RECEIVED

DEC 16 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

443  
932

12240

Reg. Dist. No. 38

### 1. PLACE OF DEATH:

County Baltimore

City or town Towson  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

120 E. Chesapeake Ave.

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.

City or town Towson  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 120 E. Chesapeake Ave.  
(If rural, give LOCATION)

2(a) If veteran, name war

### 3. (a) FULL NAME

Mary E. Morgan

### 3. (b) Social Security Number

4. Sex

Female

5. Color or race

Negro

6. (b) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife

George Morgan

7. Birth date of deceased (mo., day, yr.)

(Unknown) APT. 1894

8. AGE:

Years

Months

Days

If less than one day

over 65

hrs.

min.

9. Birthplace

Unknown

(Town, county, and state)

10. Usual occupation

General Housework

11. Industry or business

FATHER

12. Name

Unknown

13. Birthplace

"

MOTHER

14. Maiden name

Unknown

15. Birthplace

"

16. Informant

Balto. Co. Welfare Bd. Records

Address

Towson, Md.

17.

Burial  
(Burial, cremation, or removal, Which?)

Date thereof Dec. 31, 1948  
(month) (day) (year)

Cemetery or crematory

Pleasant Rest Cemetery

Location

Towson, Md.

18. Funeral director

John Burns' Sons

Address

Towson, Md.

19.

Jan 1, 1949  
(Date rec'd by registrar)

19.

W. Carroll Van Horn  
Deputy Registrar

Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH December 30, 1948 at 11<sup>20</sup> A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

None 19. to 19.

and that I last saw None alive on 19.

Immediate cause of death Chronic heart disease,  
Chronic myocarditis, decompensated

DURATION

Unknown

Due to

Hypertension

unk.

Due to

Arteriosclerosis

unk.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

William G. Hudson MD DME

M. D. or other

Address Towson Md

Date signed 1/30/49

MARGIN RESERVED FOR BINDING

VS A15 9.45.1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1949  
65  
184

RECEIVED  
FEB 1 1949  
BUREAU V. S.

COUNTY  
BALTIMORE HEALTH DEPARTMENT  
CERTIFICATE OF DEATH 97

Registered No. 38  
12241

1. PLACE OF DEATH:  
(a) Baltimore City, Maryland - Lutherville  
(b) Street address: Lappa Road  
(c) Hospital or institution:  
(d) Length of stay in hospital or inst. (yrs., mos., or days)  
(e) Length of stay in Baltimore (yrs., mos., or days) 88 yrs 4 months 25 days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Md (b) County Baltimore  
(c) City or town Rural Lutherville  
(If outside city or town limits, write RURAL and give town)  
(d) Street No. Lappa Rd.  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country.

3 (a) FULL NAME Charlotte Rogers Mustard

3 (b) If veteran, name war 3 (c) Social Security Account No.

4. Sex Female 5. Color or race White 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife: Wilfred P. Mustard  
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/7/1860

8. AGE: Years 88 Months 4 Days 25 If less than one day hr. min.

9. Birthplace Baltimore Md.  
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Edmund Law Rogers

13. Birthplace Baltimore Md.

14. Maiden Name Charlotte Matilda Leeds Plater

15. Birthplace "Waverly" Easton Md.

16 (a) Informant Edmund L.R. Smith

(b) Address Lutherville, Md

17 (a) Cremation (b) Date thereof 12-3-48  
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Greenmount  
Location Baltimore Md

18 (a) Funeral director Henry W. Jenkins & Sons

(b) Address 4905 YORK RD.

19 (a) Dec 3, 1948 (b) A. W. Hedrick  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 1948 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1926 to 1948, and that I last saw her alive on Dec 1 1948.

Immediate cause of death: Cerebral Arteriosclerosis

Due to: Senility

Due to:

Other Conditions: none

(Include pregnancy within 8 months of death)

Date of operation:

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide: no

(b) Date of occurrence: none at M

(c) Where did injury occur? none  
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? none  
(Specify type of place) While at work?

(e) Means of injury: none

23. Signature: S. Brown Street

Address: 712 Park Ave. Date signed: Dec 1948

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 36

12242

1. PLACE OF DEATH:

(a) Baltimore City, Maryland  
(b) Street *Catharine St. North End*  
(c) Hospital or institution *Good's Nursing Home*  
(d) Length of stay in hospital or inst. (yrs., mos., or days)  
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *MD* (b) County *Baltimore*  
(c) City or town *Catonsville*  
(If outside city or town limit, write RURAL and give location)  
(d) Street No. *5307 Old Frick Rd*  
(e) Citizen of foreign country? *No* (Yes or No)  
If yes, name country

3 (a) FULL NAME

*May G Muth*

3 (b) If veteran, name war

(c) Social Security Account No.

4. Sex *F* 5. Color or race *W* 6 (a) Single, married, widowed or divorced *Widowed*

6 (b) Name of husband or wife *Ferdinand J*  
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *3-11-1882*

8. AGE: Years *66* Months *9* Days *8* If less than one day hr. min.

9. Birthplace *Mayland*  
(Town, county, and state)

10. Usual Occupation *None*

11. Industry or business

12. Name *Michael Hyman*

13. Birthplace *MD*

14. Maiden Name *Ellen Joy*

15. Birthplace *MD*

16 (a) Informant *Ferd. Muth*

(b) Address *5307 Old Frick Rd*

17 (a) *Burial* (b) Date thereof *12-28-48*  
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Cathedral*  
Location *Baltimore*

18 (a) Funeral director *Guy A. Taylor*

(b) Address *Catonsville MD*

19 (a) *12-28-48* (b) *Dr. Harris*  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *Dec 20/48* 19 *48*, at *114* M

21. I certify that death occurred on the date above stated; that I attended deceased from *Nov 19* 1948, to *Dec 26* 1948 and that I last saw her alive on *Dec 20* 1948

Immediate cause of death

*myocarditis*

Duration  
*about 1 mo*

Due to *advanced arteriosclerosis*

*about 10 yrs.*

Due to *Arthritis*

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?  
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

*Harry S. Harris*

M. D.

Address

Date signed

*Dec 27/48*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

12243

41

## 1. PLACE OF DEATH:

County Balto  
 City or town Quindack  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Balto  
 City or town Severn Side  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. Rural  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Grace E. Myers

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Married

6. (b) Name of husband or wife

Louis S. Myers Sr

7. Birth date of

deceased (mo., day, yr.)

Feb 28<sup>th</sup> 1883

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

65 9 17 hrs. min.

9. Birthplace

Balto. Md.  
 (Town, county, and state)

10. Usual occupation

(Balto. Md.)

11. Industry or business

At Home

FATHER

12. Name

Nelson Thomas

13. Birthplace

Unknown

MOTHER

14. Maiden name

Lina Stash

15. Birthplace

Balto. Md.

16. Informant

Louis S. Myers Jr

Address

Riva a. a. Co. Md.

17.

(Burial, cremation, or removal, which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Glen Haven

Location

Glenburris a. a. Co. Md.

18. Funeral director

William Cook Inc.

Address

127 St. Paul St.

19.

(Date rec'd by registrar)

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Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 15<sup>th</sup> 1948 at 12<sup>20</sup> a. m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

December 5 1948 to Dec. 15 1948and that I last saw her alive on Dec. 13 1948

Immediate cause of death

Cerebral apoplexy

Due to

Hypertension

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Maxwell H. Mund

M. D. or other

Address

417 1/2 Eastern Ave

Date signed

12-16-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH 93d

Reg. Dist. No. 33

12244

## 1. PLACE OF DEATH

County BaltimoreCity or town Boring Rural  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Horace T Naim

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

March 4 - 1886

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

62913

hrs.

min.

9. Birthplace

md

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

General

FATHER

12. Name

Horatio T Naim

13. Birthplace

md

MOTHER

14. Maiden name

Sarah T Meus

15. Birthplace

md

16. Informant

Francis Naim

Address

Reisterstown md

17.

Burial  
(Burial, cremation, or removal, which?)

Date thereof

Dec 20/48  
(month) (day) (year)

Cemetery or crematory

all saints

Location

Reisterstown, Baltimore md

18. Funeral director

Edw E Gipton

Address

Handstead md

19.

12-18- 19 48  
(Date rec'd by registrar)Mary B E Line

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Boring Rural  
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

December 17 19 48 at 8 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 4 19 48 to December 17 19 48.and that I last saw him alive on December 10 19 48.

Immediate cause of death

Coronary Occlusion Sudden

Due to

Chronic Myocarditis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Joseph E Bush md

M. D. or other

Address

Handstead mdDate signed 12-17-48

RECEIVED  
DEC 22 1948  
BUREAU A. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 42

## 1. PLACE OF DEATH:

County... Baltimore

City or town... Arbutus

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

JACKSON J. NEWLIN

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Olea B.

## 7. Birth date of

deceased (mo., day, yr.)

Nov. 24, 1878, Colo.

## 8. AGE:

Years

Months

Days

If less than one day

70

0

10

hrs.

min.

## 9. Birthplace

Colorado Springs, Colo.

(Town, county, and state)

## 10. Usual occupation

Blueprinter

## 11. Industry or business

B&amp;O R.R.

## MOTHER

## 12. Name

John Newlin

## 13. Birthplace

Unknown

## 14. Maiden name

Unknown

## 15. Birthplace

Unknown

## 16. Informant

Olea B. Newlin

## Address

4602 Leeds Ave.

## 17. Burial

(Burial, cremation, or removal, Which?)

Date thereof 12/7/48

(month) (day) (year)

## Cemetery or crematory

Woodlawn

## Location

Woodlawn, Md.

## 18. Funeral director

William Cook, Inc.

## Address

1217 St. Paul St.

## 19. Dec 6

(Date rec'd by registrar)

19 48

A. W. Dedrick

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md County... Baltimore

City or town... Arbutus

(If outside city or town limits, write RURAL and give nearest town)

Street No... 4602 Leeds Ave.

(If rural, give LOCATION)

2. (a) If veteran, name war... No

## 3. (b) Social Security Number

705-09-1229

## MEDICAL CERTIFICATION

2D. DATE OF DEATH... Dec. 4, 1948... 8:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 28 19 48, to Dec 4 19 48

and that I last saw him alive on Dec 3 19 48

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

M. D. or other

Address 721 Medical Center Date signed 12/6/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 12316

## 1. PLACE OF DEATH:

County Baltimore CountyCity or town Woodlawn  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore Co.City or town Woodlawn  
(If outside city or town limits, write RURAL and give nearest town)Street No. 7107 Windsor Mill Rd.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Eugene L. Newton

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6.(a) Single, married, widowed, or divorced

Married

## 6.(b) Name of husband or wife

Maudie Roberts Newton

## 6.(c) If alive, give age years

## 7. Birth date of

deceased (mo., day, yr.)

April 28 1875

## 8. AGE:

Years

73

Months

7

Days

20

If less than one day

hrs.

min.

## 9. Birthplace

Maryland

(Town, county, and state)

## 10. Usual occupation

(Retired) Florist

## 11. Industry or business

Florist

## FATHER

## 12. Name

Wm. Morgan Newton

## 13. Birthplace

Ind.

## MOTHER

## 14. Maiden name

Ruby Rebecca Leland

## 15. Birthplace

Va.

## 16. Informant

Mrs. Maudie R. Newton

## Address

7107 Windsor Mill Rd.

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

12-21-48  
(month) (day) (year)

## Cemetery or crematory

Woodlawn Mem.

## Location

Woodlawn Md.

## 16. Funeral director

Geo. L. Beyer Jr.

## Address

1512 Hollins St.

## 19.

December 21, 48  
(Date rec'd by registrar)A. W. Beach  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 18 1948 at 2 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 23 1937 to Dec 18 1948and that I last saw him alive on Dec 3 1948

Immediate cause of death

Chronic Myocardial Degener.

DURATION

5 yrs.

Due to

Advanced Atherosclerosis5 yrs.

Due to

Paget's Disease of Bone22 yrs.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations No operation

Date of op.

Autopsy results

No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

Joshua H. Armacost M.D.

M. D. or other

Address

6419 Windsor Mill Rd.

Date signed

12/18/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH *93d*

12247

Reg. Diat. No. *3/*

## 1. PLACE OF DEATH:

County *Baltimore*City or town *Daniels*  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Baltimore*City or town *Daniels*  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

*Annie Lee Oates*

## 3. (b) Social Security Number

*X*

4. Sex:

*W*

5. Color or race

*F*

6. (a) Single, married, widowed, or divorced

*Widow*6. (b) Name of husband or wife *Jean D. Oates*

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of

deceased (mo., day, yr.)

*September 22 1878*

8. AGE:

Years

Months

Days

If less than one day

*70**2**12*

hrs.

min.

9. Birthplace

*Va.*

(Town, county, and state)

10. Usual occupation *At Home*

11. Industry or business

FATHER

12. Name

*Unknown*

13. Birthplace

*It*

MOTHER

14. Maiden name

*It*

15. Birthplace

*It*16. Informant *Mrs. Gertrude Anderson*

Address

*Daniels Md*17. *Burial*  
(Burial, cremation, or removal. Which?)

Date thereof

*12-7-48*  
(month) (day) (year)Cemetery or crematory *Good Shepherd*Location *Ellicott City Md*18. Funeral director *F. C. Higinbotham*

Address

*Ellicott City Md*19. *12/5/48*  
(Date rec'd by registrar)19. *48**Wm. E. Martin*

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH *December 4 1948* at *7:45 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*1944, to Dec 4, 1948*and that I last saw him/her alive on *Dec 3, 1948*

Immediate cause of death

DURATION

*Cardio-Vascular Disease*

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE

*Wm. E. Martin*  
*Randalltown* M. D. or other  
Date signed *12/3/48*



RECEIVED

DEC 20 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

12248

## 1. PLACE OF DEATH:

County Baltimore  
City or town Reston  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:  
Int. Pleasant SanatoriumHow long in hospital or institution? 1 year2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)State Maryland County Baltimore  
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 3904 1/2 Boorman Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Rele Oberman

## 3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Morris Oberman7. Birth date 11/30/11 6. (c) If alive, give age 47 years  
deceased (mo., day, yr.) November 29/11/19018. AGE: Years 37 Months 13/9/1 Days 15/4 30 or less than one day  
hrs. min.9. Birthplace Baltimore, Md.  
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Benjamin Bernstein13. Birthplace Poland14. Maiden name Sarah Rubenstein15. Birthplace Russia16. Informant Carrie Bernstein (sister)Address 3904 1/2 Boorman Ave Balt Md17. Burial Date thereof Dec 5/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Hebrew Herring Run Cem.Location Phila. Rd. Balto. Md.18. Funeral director Sol Greenman BrosAddress 1124 W North Ave19. 12-4-1948 Dr. E. E. Nichols  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 4 1948 at 1 p M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Dec 2, 1947, to Dec. 4 1948and that I last saw him alive on Dec. 4 1948Immediate cause of death Myocardial FailureDue to Pulmonary Tuberculosis 2 years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. Proctor MD M.D. or otherAddress Reston, Md Date signed Dec. 4, 1948

MARGIN RESERVED FOR BINDING

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VS-A15

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

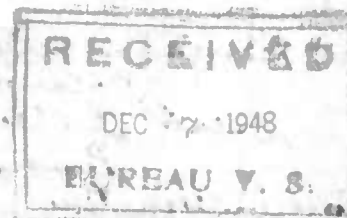
9-45-1

PLEASE

WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

### 1. PLACE OF DEATH:

County Baltimore  
City or town Fort Howard  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 43 days  
Hospital, institution, or street address where death occurred:  
V. A. H., Fort Howard, Maryland  
How long in hospital or institution? 43 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County .....  
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 240 S. Calhoun Street  
(If rural, give LOCATION)  
2. (a) If veteran, name war WW II ✓

### 3. (a) FULL NAME

MAX THOMAS OGDEN

### 3. (b) Social Security Number

217-09-9790

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married (separated)

6. (b) Name of husband or wife Mrs. Edna Ogden  
7. Birth date of deceased (mo., day, yr.) 8-29-17 6. (c) If alive, give age 27 years

8. AGE: Years 31 Months 3 Days 4 If less than one day ..... hrs. .... min.

9. Birthplace Baltimore, Maryland  
(Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business

12. Name Thomas Ogden

13. Birthplace Baltimore, Maryland

14. Maiden name Gladys Fletcher

15. Birthplace Baltimore, Maryland

16. Informant Clinical Records Vet. Adm. Hosp.

Address Fort Howard, Maryland

17. Burial Date thereof Dec 6 - 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Baltimore National Cemetery

Location Baltimore, Maryland

18. Funeral director Frederick A. Cole

Address 1200 W. Lombard St., Baltimore, Md.

19. 12/6 19 48 E. W. Hedlund  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH December 3 19 48 at 1:00P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 21 19 48 to December 3 19 48  
and that I last saw him alive on December 3 19 48

Immediate cause of death CHRONIC NEPHRITIS

Due to Unknown

Due to

Other conditions None

(Include pregnancy within 8 months of death)

Major findings of operation

Date of op.

Autopsy results Substantiated Above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Joseph Alvarez M. D. or other

Address VAH, FORT HOWARD, MD. Date signed 12-3-48

DEATH <sup>1602</sup> 12250

MARYLAND STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF STILLBIRTH

Reg. Dist. No. 4

A certificate must be filed within 24 hours for every still birth of 20 weeks' gestation or more (see stub)

**1. PLACE OF BIRTH:**

County Baltimore 22  
City or town Inner Harbor  
(If outside city or town limits, write RURAL and give nearest town)  
Street address, hospital, or institution:  
307 Calvert Way  
Length of mother's stay in County 19 hr  
(How many years, or months, or days. SPECIFY WHICH)

**2. USUAL RESIDENCE OF MOTHER:**

State MD  
County Prince Georges  
City or town Prince Georges  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 1900  
(If RURAL give LOCATION)

3. Name of child none  
4. Sex m 5. Twin or triplet m

6. Date of birth 12-4 1948 Hour 5:00 A.M.  
7. No. of weeks pregnancy 32

**FATHER OF CHILD**

8. Full name Charles Oglesby  
9. Color C 10. Age at time of this birth 29 yrs.  
11. Usual occupation laborer

**MOTHER OF CHILD**

12. Full maiden name Mildred Smith  
13. Color C 14. Age at time of this birth 23 yrs.  
15. Usual occupation housewife

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 4  
(b) How many other children were born alive but are now dead? 2 (c) How many other children were born dead? 2

17. Did child die before labor? m During labor? x

18. Pregnancy, complications of none

19. Labor: (a) Complications of cord around neck  
(b) Induced? x

20. (a) Was there an operation for delivery? none  
(b) State all operations, if any (Yes or No)

(c) Did child die before operation? m  
During operation?

23. (a) BURIAL (b) Date thereof 12-6-48  
(Burial, cremation or removal) (month) (day) (year)

(c) Cemetery or crematory Int. Cemetery

24. (a) Funeral director Joseph B. Cook, Jr.  
(b) Address 3647 Central Ave

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.

(a) Fetal causes Cord around neck

(b) Maternal causes none

22. I certify to the birth of this child who was born dead\* on the date and hour above stated.

Signature William A. Smith, Jr.  
(Specify if M. D., midwife, or other)

Address 473 Chestnut St.

25. (a) 12-6-48 (b) A. W. McEachern  
(Date rec'd by registrar) (Registrar)

26. (To be filled out if no physician was present at delivery.)  
The above certificate has been examined by me.

Health Officer, per \_\_\_\_\_

\* See Instruction C on stub.

Child  
lived  
5  
minutes  
(?)

\* Evidence for additions on items 3a and 12: ins. MARYLAND STATE DEPARTMENT OF HEALTH  
Pol. filmed G118 12-17-48 DM 2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 38

12251

1. PLACE OF DEATH:

County Baltimore  
City or town Towson 4, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? Since July 31, 1947  
Hospital, institution, or street address where death occurred:  
Eudowood Sanatorium, Towson 4, Maryland  
How long in hospital or institution? Since July 31, 1947

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore City  
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 1719 E Lombard  
(If rural, give LOCATION)  
2. (a) If veteran, name war ✓

3. (a) FULL NAME

Peter Oleszczuk or Oleszczuk  
or Piotr Oleszczuk \*

3. (b) Social Security Number

213-07-0872

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

deceased Antanette Oleszczuk

7. Birth date of deceased (mo., day, yr.)

December 8, 1896

6. (c) If alive, give age ..... years

8. AGE:

Years

Months

Days

If less than one day

52

3

hrs.

min.

9. Birthplace

Poland

(Town, county, and state)

10. Usual occupation

Mill worker

11. Industry or business

FATHER  
MOTHER

12. Name Piotr Oleszczuk or Oleszczuk \*

13. Birthplace Poland

14. Maiden name Mary Pisarch

15. Birthplace Poland

16. Informant Personal history-hospital records

Address Eudowood Sanatorium, Towson 4, Md.

17.

Burial Date thereof 12-14-48  
(Burial, cremation, or removal, Which? (month) (day) (year))

Cemetery or crematory St. Stanislaus Blem

Location Dundalk Ave

18. Funeral director

Stephen J. Galloway

Address 1000 S. Carroll

19.

12/13/48 19 48  
(Date recorded by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 11, 1948 at 11:25 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 31, 1947 to December 11, 1948  
and that I last saw him alive on December 10, 1948

Immediate cause of death

Pulmonary tuberculosis

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

SIGNATURE W. A. Bridges

Address Towson 4, Md.

Date signed 12-11-48

MARGIN RESERVED FOR BINDING

9-45-15

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

12252

Reg. Dist. No. 32

## 1. PLACE OF DEATH:

County BaltimoreCity or town Greenspring Valley  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Railroad Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltimoreCity or town Greenspring Valley  
(If outside city or town limits, write RURAL and give nearest town)Street No. Railroad Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

RANSON OLIVER

## 3. (b) Social Security Number

214-01-2996

4. Sex <u>Male</u>	5. Color or race <u>Colored</u>	6. (a) Single, married, widowed, or divorced <u>Single</u>
-----------------------	------------------------------------	---

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) August 17, 1887

8. AGE:	Years	Months	Days	If less than one day
	<u>61</u>	<u>3</u>	<u>23</u>	hrs. min.

9. Birthplace Georgia  
(Town, county, and state)10. Usual occupation Laborer

11. Industry or business

12. Name Archer Oliver13. Birthplace Georgia14. Maiden name Unknown15. Birthplace Georgia16. Informant Mr. Zack OliverAddress Greenspring Valley, Balto. Co.17. Burial Date thereof 12-12-48  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Mt. Calvary Cem.Location Anne Arundel Co., Md.18. Funeral director Mrs. Frances A. HensleyAddress 578 W. Biddle St.19. December 19, 48 R. W. Hedrick  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 8, 1948 8:10 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-8-'48 to 12-8-'48and that I last saw him alive on not seen aliveImmediate cause of death Arteriosclerotic C-V. Disease DURATION 2 yrs. est.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

NONE Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? NONE  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE D. D. Caples, M.D. Med Exam.  
M. D. or otherAddress Reisterstown, Md. Date signed 12-9-'48

MARGIN RESERVED FOR BINDING

VS 415 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

12253

32

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 4 yrs., 6 mos., 7 days.  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution? 4 yrs., 6 mos., 7 days.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County \_\_\_\_\_  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 600 W. Lexington Street  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Walter Peas (Pease)

## 3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed  
 6. (b) Name of husband or wife Rose Stocking  
 7. Birth date of deceased (mo., day, yr.) May 6, 1874 6. (c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Year 74 Months 7 Days 2 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Baltimore, Maryland  
 (Town, county, and state)  
 10. Usual occupation laborer  
 11. Industry or business Building  
 12. Name Charles Peas  
 13. Birthplace Maryland  
 14. Maiden name Mary Gardner  
 15. Birthplace Maryland

16. Informant Hospital records  
 Address Catonsville-28, Maryland  
 17. Burial Date thereof 12/11/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory New Cathedral Cean  
 Location 4300 Old Frederick Rd  
 18. Funeral director John J. Cowan & Son  
 Address 601-103 Hollins St  
 19. Dec 11 19 48 A. W. B. Buck  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 8 19 48 at 10:10 p  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
May 31 19 44 to Dec. 8 19 48  
 and that I saw him alive on December 8 19 48

Immediate cause of death Terminal pneumonia DURATION 48 hrs.  
48 hrs.  
 Due to Gangrene left great toe  
 Due to \_\_\_\_\_  
 Other conditions Generalized arteriosclerosis indef.  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results none  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
 23. SIGNATURE Isadore Tuerk, M.D. M. D. or other \_\_\_\_\_  
 Address Catonsville-28, Md. Date signed 12/9/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

EVIDENCE FOR NOTATION IN # 21 IS ON: 2411 N. Charles St., Baltimore

FILM No. G 119 MAR 21 1949 CERTIFICATE OF DEATH

Reg. Dist. No.

<b>1. PLACE OF DEATH:</b> County... <u>Baltimore</u> City or town... <u>Towson</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? Hospital, institution, or street address where death occurred: <u>Falls Road</u> How long in hospital or institution?				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State... <u>Md</u> County... <u>Baltimore</u> City or town... <u>Towson</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>Falls Road</u> (If rural, give LOCATION) 2.(a) If veteran, name war...											
<b>3. (a) FULL NAME</b> <u>CHARLES E. POWELL</u>				<b>3. (b) Social Security Number</b> <u>None</u>											
<b>4. Sex</b> <u>Male</u>				<b>5. Color or race</b> <u>White</u>		<b>6. (a) Single, married, widowed, or divorced</b> <u>Married</u>									
<b>6. (b) Name of husband or wife</b> <u>Blanche Alban</u>				<b>6. (c) If alive, give age</b> ... years											
<b>7. Birth date of deceased (mo., day, yr.)</b> <u>October 10, 1889</u>				<b>8. AGE:</b> <table border="1"> <tr> <th>Years</th> <th>Months</th> <th>Days</th> <th>If less than one day</th> </tr> <tr> <td><u>59</u></td> <td><u>2</u></td> <td><u>3</u></td> <td>hrs. min.</td> </tr> </table>				Years	Months	Days	If less than one day	<u>59</u>	<u>2</u>	<u>3</u>	hrs. min.
Years	Months	Days	If less than one day												
<u>59</u>	<u>2</u>	<u>3</u>	hrs. min.												
<b>9. Birthplace</b> <u>Baltimore County, Md.</u> (Town, county, and state)				<b>10. Usual occupation</b> <u>Hardwood Floor Finisher</u>											
<b>11. Industry or business</b>				<b>12. Name</b> <u>Lewis N. Powell</u>											
<b>13. Birthplace</b> <u>Va.</u>				<b>14. Maiden name</b> <u>Amelia Tracy</u>											
<b>15. Birthplace</b> <u>Baltimore County, Md.</u>				<b>16. Informant</b> <u>Mrs Blanche Powell</u> Address <u>Falls Road</u>											
<b>17. Burial</b> (Burial, cremation, or removal, Which?) <u>Burial</u> Date thereof <u>12/16/48</u> (month) (day) (year) Cemetery or crematory <u>Loudon Park</u> Location <u>Baltimore, Md.</u>				<b>18. Funeral director</b> <u>William Cook, Inc.</u> Address <u>1217 St. Paul St.</u>											
<b>19. 12/14</b> (Date rec'd by registrar)				<b>20. 12/13/48</b> (Date signed by physician)											

<b>20. DATE OF DEATH</b> <u>December 13, 1948</u> at <u>12:30 AM</u>	
<b>21. I CERTIFY that death occurred on the date above stated; that I attended deceased from</b> <u>11-13</u> 19 <u>48</u> to <u>12-13</u> 19 <u>48</u> and that I last saw him alive on <u>12-12</u> 19 <u>48</u>	
<b>Immediate cause of death</b> <u>Rupture, Aneurysm, Aorta; nonhypertensive</u>	<b>DURATION</b> <u>14 yr.</u>
<b>Due to</b> <u>Aneurysm - Aorta Aorta</u>	<u>Weak</u>
<b>Other conditions</b> <u>Cholecystitis &amp; Cholelithiasis</u>	
(Include pregnancy within 3 months of death) <b>Major findings of operations</b> <u>Cholecystitis &amp; Cholelithiasis</u>	
<b>Autopsy results</b> <u>None</u>	
<b>PHYSICIAN: Please underline the cause to which death should be charged statistically.</b>	
<b>22. VIOLENCE: If death was due to external causes, fill in the following:</b> Accident, suicide, or homicide... Date of <u>12/30/48</u> Where did injury occur? (City or town) (County) (State) Injured at home, farm, industry, public place (where?) Means of injury Injured at work? <u>Bennett A. Stoen</u> <b>23. SIGNATURE</b> <u>Lutherville</u> M. D. or other Address Date signed <u>12/13/48</u>	

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

12255

93d

Reg. Dist. No.

38

### 1. PLACE OF DEATH:

County Baltimore

City or town Towson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

206 Washington Avenue

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Towson

(If outside city or town limits, write RURAL and give nearest town)

Street No. 206 Washington Avenue

(If rural give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

ELLEN CAPEWELL READ

### 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife William Charles Read

7. Birth date of

deceased (mo., day, yr.)

June 24, 1874

6. (c) If alive, give age \_\_\_\_\_ years

8. AGE:

Years

Months

Days

If less than one day

74

5

18

hrs.

min.

9. Birthplace

New Jersey

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

At Home

FATHER

12. Name

Unknown Capewell

13. Birthplace

Unknown

MOTHER

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

Mr. William Barall

Address

6517 Sherwood Rd., Balto. Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof Dec. 15, 1948

(month) (day) (year)

Cemetery or crematory

Riverview Cemetery

Location

Trenton, New Jersey

18. Funeral director

John Burnie's Sons

Address

Towson, Maryland

19.

(Date rec'd by registrar)

Dec. 14

19 48

W. Carmel Van Horn

Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH December 12, 1948 at 3 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar 2 19 48, to Dec 12 19 48

and that I last saw him alive on Dec 11, 1948

Immediate cause of death

Chronic myocarditis

DURATION

1942

Due to

Auto cardiac death

1948

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Guy W. Bush

M. D. or other

Address

573 Shore a

Date signed

12/13/48

MARGIN RESERVED FOR BINDING

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 3 1949

BUREAU V. E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 12256

## 1. PLACE OF DEATH:

County BaltimoreCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Anthony Reda

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of spouse or wife Anna Reda

7. Birth date of deceased (mo., day, yr.)

January 17 1889

6. (c) If alive, give age..... years

8. AGE:

59

Years

Months

10

Days

23

If less than one day

hrs.

min.

9. Birthplace Cerisano Cosenza Italy  
(Town, county, and state)10. Usual occupation Post Office Work11. Industry or business Bethlehem Steel Co. (Sparrows Pt. Md)

FATHER

12. Name Luigi Reda13. Birthplace Italy

MOTHER

14. Maiden name Luisa ?15. Birthplace Italy16. Informant Anna Reda (Wife)Address 631 S. Macon St.17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Dec. 13 1948

(month) (day) (year)

Cemetery Sacred HeartLocation German Hill Rd. Dundalk Md.18. Funeral director Frank Della NoceAddress 322 S. High St.19. Dec 11 1948  
(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md

County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 631 S. Macon St.

(If rural, give LOCATION)

2. (a) If veteran, name war.....

## 3. (b) Social Security Number

213-07-9438

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 10 1948 at 8:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19.....

to.....

19.....

and that I last saw him..... alive on.....

19.....

Immediate cause of death.....

DURATION

Coronary Occlusion

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur? Home

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE M.D. Davis

M. D. or other

Address.....

Date signed 12/10/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Fort Howard  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 21 Days  
 Hospital, institution, or street address where death occurred:  
Vets. Adm. Hospital, Ft. Howard, Md.  
 How long in hospital or institution? 21 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County .....  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 2305 E. Biddle Street  
 (If rural, give LOCATION)  
 2. (a) Is veteran, name war WW-I

## 3. (a) FULL NAME

JACK R. REDMOND

## 3. (b) Social Security Number

Unknown 213-05-0704

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Lorie Redmond  
 6. (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) 8-27-1897  
 8. AGE: Years Months Days It less than one day  
51 3 19 ..... hrs. .... min.

9. Birthplace Charleston, S. C.  
 (Town, county, and state)

10. Usual occupation Carpenter

## 11. Industry or business

FATHER 12. Name Jack Redmond  
 13. Birthplace South Carolina  
 MOTHER 14. Maiden name Callie Clark  
 15. Birthplace South Carolina

16. Informant Clinical Records, Vets. Adm. Hosp.  
Fort Howard, Maryland  
 Address

17. Removal Date thereof 12/18/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory .....  
 Location Charleston, S. C. (J. W. Connelley)  
 18. Funeral director Howard Blight Howard W. Blight Jr.  
 Address 6009 Harford Rd., Balto., Md.

19. 11/7/48 Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 16, 1948 1:05 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
November 24, 1948 to December 16, 1948  
 and that I last saw him alive on December 16, 1948

Immediate cause of death HEMORRHAGE INTO  
GASTRO-INTESTINAL TRACT DURATION 2 Weeks

Due to Laennec's Cirrhosis of Liver

Due to .....

Other conditions Bronchopneumonia of left  
lower lobe.  
 (Include pregnancy within 8 months of death)

Major findings of operations .....

Date of op. ....

Autopsy results Substantiated above  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Wilton Custer, M.D. M. D. or otherAddress VAH, Fort Howard, Md. Date signed 12/26/48

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. **30**

### 1. PLACE OF DEATH:

County **Baltimore**  
City or town **Catonsville**  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? **13 yrs., 6 mos., 26 days**  
Hospital, institution, or street address where death occurred:  
**Spring Grove State Hospital**  
How long in hospital or institution? **13 yrs., 6 mos., 26 days**

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....  
City or town **Address unknown**  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.....  
(If rural, give LOCATION)  
2. (a) If veteran, name war.....

### 3. (a) FULL NAME

**Ora Rehm**

### 3. (b) Social Security Number

4. Sex **female** 5. Color or race **white** 6. (a) Single, married, widowed, or divorced **divorced**

6. (b) Name of husband or wife **Unknown**

7. Birth date of deceased (mo., day, yr.) **October 10, 1886** 6. (c) If alive, give age..... years

8. AGE: Years **62** Months **2** Days **20** If less than one day..... hrs. .... min.

9. Birthplace **Baltimore, Maryland**  
(Town, county, and state)

10. Usual occupation **None**

11. Industry or business **"**

12. Name **James P. Keaton**

13. Birthplace **Virginia**

14. Maiden name **Roberta Vaughan**

15. Birthplace **Virginia**

16. Informant **Hospital Records**

Address **Catonsville-28-Maryland**

17. **Burial** Date thereof **1/13/49**  
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory **Mt Carmel**

Location **Balto. Md.**

18. Funeral director **William Cook, Inc.**

Address **1217 St. Paul St.**

19. **1/3** 29 **Dr. W. Hedrick**  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH **December 30** 19**48** at **11:05 AM**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **June 4** 19**35** to **December 30** 19**48** and that I last saw him/her alive on **December 30** 19**48**

Immediate cause of death **Coronary Occlusion** **15 min.**  
**Coronary Sclerosis** **Indefinite**  
Due to **Arteriosclerotic C.V. Disease** **"**  
**Cardiac decompensation** **3 months**  
Due to **Hypertensive C. V. Disease** **Indefinite**

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results **None**  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE **Isadore Tuerk, M.D.** M. D. or other

Address **Catonsville-28-Maryland** Date signed **12/30/48**

MARGIN RESERVED FOR BINDING

VS-A16

9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 12259 30

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 10 years, 2 months, 7 days  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution? 10 years, 2 months, 7 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County \_\_\_\_\_  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1922 East Chase Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3.(a) FULL NAME

Virgil Rehm

## 3.(b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced single  
 6.(b) Name of husband or wife \_\_\_\_\_  
 7. Birth date of deceased (mo., day, yr.) March 24, 1912  
 8. AGE: Years 36 Months 8 Days 12 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Baltimore, Maryland  
 (Town, county, and state)  
 10. Usual occupation Laborer  
 11. Industry or business Mattress factory  
 12. Name Harry Rehm  
 13. Birthplace Maryland  
 14. Maiden name Jennie Hutton  
 15. Birthplace Maryland

16. Informant Hospital records  
Catonsville - 28, Maryland

17. Burial (Burial, cremation, or removal, Which?) Buried Date thereof 12-9-48  
 (month) (day) (year)  
 Cemetery or crematory Morland Mem. Park  
 Location Washington Blvd  
 18. Funeral director John C. Miller & Son  
 Address 2435 E. Ohio St  
 19. Dec 8 19 48 A. W. Kelsch  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 6 19 48 at 7:15 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

\_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_  
 and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_

Immediate cause of death

Shock (Surgical)  
from aneurysm  
acute intestinal obstruction

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

\_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of Dec 6 48  
 Where did injury occur? Catonsville Md  
 (City or town) (State)

Injured at home, farm, industry, public place, (where?) Hospital  
 Means of injury Spinal Intestinal obstruction Injured at work \_\_\_\_\_

23. SIGNATURE Dr. M. Kieffer M. D. or other Dean Bels  
 Address 1010 Leedman Date signed Dec 7 48

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

38

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? one month twenty-three days  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution? one month twenty-three days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County \_\_\_\_\_  
 City or town Baltimore City  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3904 Hadley Square West  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_ ✓

## 3. (a) FULL NAME

WILLIAM F. RIAL

## 3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced married  
 6.(b) Name of husband or wife Catherine E. Rial  
 6.(c) If alive, give age 63 years  
 7. Birth date of deceased (mo., day, yr.) December 8, 1879  
 8. AGE: Years 69 Months 0 Days 15 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Baltimore, Maryland  
 (Town, county, and state)  
 10. Usual occupation Iron Molder retired  
 11. Industry or business Iron industry (B & O)  
 12. Name William F. Rial  
 13. Birthplace Baltimore, Maryland  
 14. Maiden name Elizabeth Krieb  
 15. Birthplace Baltimore, Maryland

16. Informant Hospital Records  
 Address Catonsville 28, Md.  
 17. Burial Date thereof 12/27/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Lorraine Cem.  
Woodlawn, Md.  
 Location \_\_\_\_\_  
 18. Funeral director WM. J. TICKNER & SONS  
Balto., Md.  
 Address \_\_\_\_\_

19. Dec 23 19 48 a. w. Beckner  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 23, 1948 at 1 a. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
October 30, 1948 to December 23, 1948  
 and that I last saw him alive on December 23, 1948

Immediate cause of death  
Arteriosclerotic heart disease Indefinite  
Generalized arteriosclerosis Indefinite  
 Due to Hypertensive cardiovascular disease Indefinite  
 Due to \_\_\_\_\_  
 Other conditions Left hemiplegia Indefinite

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results none  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, pub'c place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
 23. SIGNATURE Isadore Tuerk, M.D. M. D. or other \_\_\_\_\_  
 Address Catonsville 28, Md. Date signed 12/23/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH: *Babto. Catonsville*  
 County.....  
 City or town..... *177-Winters Ave.*  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

*Henrietta Richardson*

3. (b) Social Security Number

4. Sex *Fr.* 5. Color or race *Col.* 6. (a) Single, married, widowed, or divorced *Widow*  
 6. (b) Name of husband or wife.....  
 7. Birth date of deceased (mo., day, yr.) *July 4, 1885*  
 8. AGE: Years *63* Months *md.* Days *md.* If less than one day  
 hrs. min.

9. Birthplace.....  
 (Town, county, and state)  
 10. Usual occupation *unemployed*  
 11. Industry or business *John Henry Thorne*  
 12. Name.....  
 13. Birthplace *Mathias J. Tasco*  
 14. Maiden name.....  
 15. Birthplace *md.*

16. Informant *Ada. J. Webb.*  
 Address *177-Winters Ave*  
 17. *Burial* Date thereof *12-18-48*  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *Broens Chapel Cent.*  
 Location *W. Halstead*

18. Funeral director *W. Halstead*  
 Address *918-Howard St*

19. *Dec 18 1948* 19. H. *W. Halstead*  
 (Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *md.* County.....  
 City or town..... *Catonsville*  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. *177-Winters Ave.*  
 (If rural, give LOCATION)

2. (a) If veteran, name war.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH *Dec-15-48* 19 *48* at *8 AM*

21. CERTIFY that death occurred on the date above stated; that I attended deceased from *Nov-6-48* 19 *48* to *Dec-15-48* 19 *48*  
 and that I last saw her alive on *12-15-48* 19 *48*

Immediate cause of death

DURATION

*Mitral Insufficiency ?*  
 Due to *Cardiac Renal*  
 Due to *this case* ?

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury

Injured at work?

23. SIGNATURE *B. F. Maloney MD* M. D. or otherAddress *Catonsville - Md* Date signed *12/15/48*



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 41

12262

### 1. PLACE OF DEATH:

County Baltimore  
City or town Dundalk  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

6703 Thruway

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Baltimore

City or town Dundalk  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6703 Thruway  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

Ralph H. Rodgers

### 3. (b) Social Security Number

4. Sex

M.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

S.

### MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 16 1948, at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 20 1949, to Dec 16 1948.

and that I last saw him alive on Dec 16 1948.

Immediate cause of death

Myocardial infarction  
cerebellum

DURATION

14 months

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings and operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Eugene F. Neary  
7001 Mornington Rd.  
Dundalk, Md.

or other

Date signed 12-18-48

19. Dec 18 1948  
(Date rec'd by registrar)

Wm. M. Kelly, Jr.  
Registrar

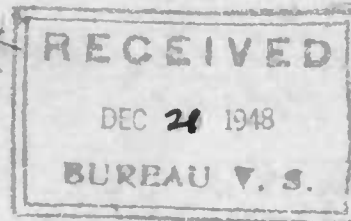
MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



11-  
1948-X2-X6  
1941-5-27  
7-6-19



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

12263

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County... Baltimore County, Maryland  
 City or town... Rural - Baltimore Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 25 years  
 Hospital, institution, or street address where death occurred: —

How long in hospital or institution? 2 months

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... Maryland County... Baltimore  
 City or town... Rural - Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 413 Middle River Rd  
 (If rural, give LOCATION)

2.(a) If veteran, name war. —

## 3. (a) FULL NAME

Edith Mae Rolner

## 3. (b) Social Security Number

none

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Ernest J Rolner6. (c) If alive, give age 43 years

## 7. Birth date of deceased (mo., day, yr.)

May 18, 1906

## 8. AGE:

42 Years6 Months26 DaysIf less than one day  
hrs. min.

## 9. Birthplace

Baltimore County, Maryland  
(Town, county, and state)

## 10. Usual occupation

House wife

## 11. Industry or business

## FATHER

## 12. Name

William Howell

## 13. Birthplace

Baltimore Co. Maryland

## MOTHER

## 14. Maiden name

Eva Morris

## 15. Birthplace

Baltimore County, Maryland

## 16. Informant

Husband: Ernest J Rolner

## Address

413 Middle River Rd Baltimore Md

## 17. (Burial, cremation, or removal. Which?)

burial

Date thereof

Dec. 18, 1948  
(month) (day) (year)

## Cemetery or crematory

Moreland Memorial Park

## Location

Taylor Ave

## 18. Funeral director

Lassahn Funeral Homes

## Address

7401 Belair Rd.

## 19.

12-14-48  
(Date rec'd by registrar)

19.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... December 14 19 48 at 9 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

October 16 19 48 to Dec. 12 19 48and that I last saw him alive on Dec. 12 19 48

Immediate cause of death

Carcinoma of Rectum  
with metastases to liver

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Carcinoma of Rectum

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Henry R Sech MD

Address

901 Funchay Ave Baltimore MdDate signed 12/14/48

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 yr., 9 mos., 20 days  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution? 1 yr., 9 mos., 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County \_\_\_\_\_  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Mt. Sinai Nursing Home-4613 Park Hgts.  
 (If rural, give LOCATION) Avenue  
 2. (a) If veteran, name war Police

## 3. (a) FULL NAME

Louis Roginski

## 3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced separated  
 6. (b) Name of husband or wife Miriam Geller  
 6. (c) If alive, give age 69 years  
 7. Birth date of deceased (mo., day, yr.) March 15, 1874  
 8. AGE: Years 74 Months 9 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Russia  
 (Town, county, and state)  
 10. Usual occupation bricklayer  
 11. Industry or business Construction  
 12. Name Unknown  
 13. Birthplace \_\_\_\_\_  
 14. Maiden name Unknown  
 15. Birthplace \_\_\_\_\_

16. Informant Hospital Records  
 Address Catonsville-28-Maryland  
 17. Burial Date thereof 12-16-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory \_\_\_\_\_  
 Location Abraham Mt Carmel  
 18. Funeral director Jack Lewis Inc  
 Address 2400 Eutaw Place  
 19. 12-15 19 48 V.E. Harris  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 15 19 48 at 12:42 a  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 25 19 47 to December 15 19 48  
 and that I last saw him alive on December 15 19 48  
 Immediate cause of death Terminal pneumonia DURATION 4 days  
 Due to arteriosclerotic cardiovascular renal disease indef.  
 Due to \_\_\_\_\_  
 Other conditions Bilateral amaurosis indef.  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results none  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
 23. SIGNATURE Isadore Tuerk, M.D. M. D. or other \_\_\_\_\_  
 Address Catonsville-28-Maryland Date signed 12-15-48

RECEIVED

DEC 17 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

### 1. PLACE OF DEATH:

County Baltimore  
City or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For whom infants give residence of mother)  
State Maryland County Howard

City or town Sechrist  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Charles Andrew Rowles

### 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed or divorced Single

6. (b) Name of husband or wife None

7. Birth date of deceased (mo., day, yr.) Jan. 20, 1869 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 79 Months 11 Days 6 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Elkridge Md.  
(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business \_\_\_\_\_

12. Name Charles Rowles

13. Birthplace Elkridge, Md.

14. Maiden name Mary C. Seimess

15. Birthplace Baltimore Md.

16. Informant Mrs. Nellie Schmidt

Address Sechrist, Md.

17. Burial Date thereof Dec. 29, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory St. Augustine Cem.

Location Elkridge, Md.

18. Funeral director Easton Sons

Address 608 Frederick Ave Catonsville

19. 12-28-48 V.E. Harry  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26, 1948 at 4:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 23, 1948 to Dec 26, 1948 and that I last saw him alive on Dec 23, 1948

Immediate cause of death Cerebral hemorrhage DURATION 78 hrs

Due to Generalized arteriosclerosis Unknown

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Stephen Lee Macneels MD M. D. or other

Address Catonsville 28, Md. Date signed 12-28-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 30 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 12366

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Parkville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 26 years  
 Hospital, institution, or street address where death occurred:  
9106 Harford Road  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Md. County Balto.  
 City or town Parkville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 9106 Harford Road  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

ISABELLE V. SCHEK

## 3. (b) Social Security Number

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed

6.(b) Name of husband or wife Charles Wm. Schek  
 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 24th, 1879  
 8. AGE: Years 69 Months 1 Days 16 If less than one day ..... hrs. .... min.

9. Birthplace Balto., Md.  
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Wm. Singleton

13. Birthplace Unknown

14. Maiden name Mary --

15. Birthplace Unknown

16. Informant Mrs. John W. Anthony

Address 9106 Harford Road, Balto. 14, Md.

17. burial Date thereof Dec. 14, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Parkwood

Location Balto., Md.

18. Funeral director Lassahur Funeral Home

Address 7401 Belair Road

19. 12/11 48 A.M. Bacon  
 (Date rec'd by registrar) (year) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 10th, 1948, at 2:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 19, 39 to Dec 10, 48 and that I last saw him alive on Dec 10, 48

Immediate cause of death Cor. dia. asthma  
Oedema of lungs  
 Due to Chronic myocarditis

DURATION  
7 yrs.  
2 mos.  
10 yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A.M. Bacon M. D. or other

Address 2810 Taylor Ave Date signed 12/11/48

RECEIVED

DEC 13 1948

BUREAU V. A.

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 9

12267

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Towson 4, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Since 11-13-48  
 Hospital, institution, or street address where death occurred:  
Eudowood Sanatorium, Towson 4, Maryland  
 How long in hospital or institution? Since 11-13-48

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore City  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3905 Reservoir Road  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war no

## 3. (a) FULL NAME

Charles S Schermerhorn

## 3. (b) Social Security Number

none

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Theresa Schermerhorn  
 (If deceased, give name and date of death) Petayik

7. Birth date of deceased (mo., day, yr.) June 9, 1906  
 6. (c) If alive, give age 26 years

8. AGE: Years 42 Months 6 Days 13 If less than one day  
 hrs. min.

9. Birthplace Catonsville, Md.  
 (Town, county, and state)

10. Usual occupation Manufacturers Representative

11. Industry or business

12. Name Morgan R. Schermerhorn

13. Birthplace Baltimore, Md.

14. Maiden name Emma Timanus

15. Birthplace Baltimore, Md.

16. Informant Personal history-Hospital records

Address Eudowood Sanatorium, Towson 4, Md.

17. Burial Date thereof 12/23/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Druid Ridge Cem.

Location Pikesville, Md.

18. Funeral director WM. J. TICKNER & SONS

Address Balto., Md.

19. 12/25 19 48 G.W. Harris  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 22 19 48 at 10:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 13 19 48 to December 21 19 48  
 and that I last saw him alive on December 21 19 48

Immediate cause of death Pulmonary Tuberculosis

Due to Since June 1946

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W.A. Bridges M. D. or other

Address Towson 4, Md. Date signed 12-22-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

12268

Reg. Dist. No. 444

<b>1. PLACE OF BIRTH</b> County <u>Baltimore</u> City or town <u>Loreley</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of birth? Hospital, institution, or street address where death occurred <u>Red Lion Rd.</u> How long in hospital or institution?		<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State <u>Md.</u> County <u>Balto</u> City or town <u>Loreley</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>Red Lion Rd.</u> (If rural, give LOCATION) 2.(a) If veteran, name war <u>#1</u>	
<b>3. (a) FULL NAME</b> <u>Martina Henry Schmidt</u>		<b>3. (b) Social Security Number</b>	
<b>4. Sex</b> <u>M.</u>	<b>5. Color or race</b> <u>W.</u>	<b>6. (a) Single, married, widowed, or divorced</b> <u>—</u>	
<b>6. (b) Name of husband or wife</b> <u>—</u>		<b>6. (c) If alive, give age</b> <u>—</u> years	
<b>7. Birth date of deceased (mo., day, yr.)</b> <u>Aug 23 - 1893</u>		<b>20. DATE OF DEATH</b> <u>Dec. 25</u> 19 <u>48</u> at <u>1:30</u> P.M.	
<b>8. AGE:</b> Years <u>55</u> Months <u>3</u> Days <u>—</u> If less than one day <u>—</u> hrs. <u>—</u> min.		<b>21. I CERTIFY that death occurred on the date above stated; that I attended deceased from</b> and that I last saw him <u>—</u> alive on <u>—</u> 19 <u>—</u>	
<b>9. Birthplace</b> <u>Balto, Md.</u> (City, county, and state)		<b>Immediate cause of death</b> <u>Coronary Occlusion</u>	
<b>10. Usual occupation</b> <u>Soldier</u>		<b>DURATION</b> <u>—</u>	
<b>11. Industry or business</b> <u>Retired</u>		<b>Due to</b> <u>—</u>	
<b>12. Name</b> <u>John H. Schmidt</u>		<b>Due to</b> <u>—</u>	
<b>13. Birthplace</b> <u>Germany</u>		<b>Other conditions</b> <u>—</u>	
<b>14. Maiden name</b> <u>Margaret Martin</u>		(Include pregnancy within 3 months of death)	
<b>15. Birthplace</b> <u>Balto., Md.</u>		<b>Major findings of operations</b> <u>None</u> Date of op. <u>—</u>	
<b>16. Informant</b> <u>Mrs. Paul Gruebl</u>		<b>Autopsy results</b> <u>—</u>	
<b>Address</b> <u>Loreley Md.</u>		<b>PHYSICIAN: Please underline the cause to which death should be charged statistically.</b>	
<b>17. (Burial, cremation, or removal, Which?)</b> <u>Burial</u> Date thereof <u>Dec. 28 - 48</u> (month) (day) (year)		<b>22. VIOLENCE: If death was due to external causes, fill in the following:</b>	
<b>Cemetery or crematory</b> <u>St. Pauls C.</u>		Accident, suicide, or homicide <u>—</u> Date of <u>—</u>	
<b>Location</b> <u>5600 Cardiff Ave.</u>		Where did injury occur? <u>—</u> (City or town) (County) (State)	
<b>18. Funeral director</b> <u>John B. Connelly</u>		Injured at home, farm, industry, public place (where?) <u>—</u>	
<b>Address</b> <u>418 Eastern Ave.</u>		Means of injury <u>—</u> Injured at work? <u>—</u>	
<b>19. (Date rec'd by registrar)</b> <u>Dec. 28th 1948</u> <u>John B. Connelly</u> Registrar		<b>23. SIGNATURE</b> <u>M. B. Davis M.D.</u>	
Address <u>—</u>		Date signed <u>Dec 26 - 48</u>	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

12269

Reg. Dist. No. 31

## 1. PLACE OF DEATH:

County BaltimoreCity or town Rockdale  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

3628 Milford Mill Road

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State M d. County BaltimoreCity or town Rockdale  
(If outside city or town limits, write RURAL and give nearest town)Street No. 3628 Milford Mill Road

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Annie W. Sharp

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female

White

Widowed

6. (b) Name of husband or wife Clarence B. Sharp

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14, 18698. AGE: Years Months Days If less than one day  
79 6 6 hrs. min.9. Birthplace Baltimore, Md.  
(Town, county, and state)10. Usual occupation None

11. Industry or business

12. Name Mr. Pryor13. Birthplace Baltimore, Md.14. Maiden name Almira Cowen15. Birthplace Baltimore, Md.16. Informant Mr. Clarence W. Sharp  
Address 3628 Milford Mill Rd., Rockdale17. Burial Date thereof Dec. 22, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mt. Olive CemeteryLocation Rockdale, Md.18. Funeral director W. L. Landon  
Address 4510 Liberty Heights Ave.19. 12/20/48 Mr. E. Martin  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 20, 1948 at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1948 to Dec. 20, 1948  
and that I last saw DE alive on Dec. 20, 1948Immediate cause of death Cardiovascular disease DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

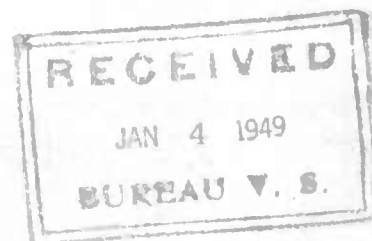
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Mr. E. Martin M. D. or otherAddress Harrisonville, Md. Date signed 12/20/48





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 35

## 1. PLACE OF DEATH:

County BaltimoreCity or town Parkton  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County BALTIMORECity or town PARKTON RT. 42  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

SARAH ELIZABETH SIMPSON

## 3. (b) Social Security Number

NONE

## 4. Sex

FEMALE

## 5. Color or race

WHITE

## 6. (a) Single, married, widowed, or divorced

WIDOW

## 6. (b) Name of husband or wife

GRANVILLE SIMPSON

## 6. (c) If alive, give age. \_\_\_\_\_ years

## 7. Birth date of

deceased (mo., day, yr.)

FEB 28 1952

## 8. AGE:

Years

Months

Days

If less than one day

96103

hrs.

min.

## 9. Birthplace

BALTIMORE Co.

(Town, county, and state)

## 10. Usual occupation

AT HOME

## 11. Industry or business

FATHER  
MOTHER

## 12. Name

EDWIN WILSON

## 13. Birthplace

BALTIMORE Co MD

## 14. Maiden name

SARAH ANN PALMER

## 15. Birthplace

BALTIMORE Co. MD

## 16. Informant

Paul Harry Simpson

## Address

5209 York Rd. Baltimore, Md

## 17.

BURIAL

## Date thereof

JAN 3-1949

(Burial, cremation, or removal. Which?)

## Cemetery or crematory

WEST LIBERTY

## Location

WHITE HALL RTD. MD

## 18. Funeral director

Howard S. Markline

## Address

White Hall. Md

## 19.

Jan 1,

19

49 Mrs Howard S. Markline

Registrar

## 23. SIGNATURE

J. L. YagleM. D. another

## Address

New Freedom PaDate signed 12/31-48

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 31- 19 48 at 1:00 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Apr. 1- 19 48 to Dec 28- 19 48and that I last saw him alive on Dec 28- 19 48

## Immediate cause of death

Cerebral Hemorrhage

## DURATION

## Due to

arterio-sclerosis

## Due to

## Other conditions

Myocardial Regeneration

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

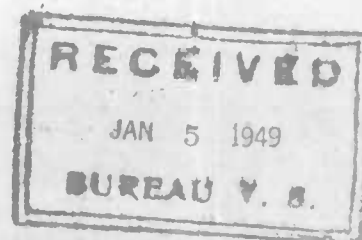
Injured at work?

## 23. SIGNATURE

J. L. YagleM. D. another

## Address

New Freedom PaDate signed 12/31-48



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

### 1. PLACE OF DEATH:

County Baltimore  
City or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 4 yrs., 1 mo., 27 days.  
Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
How long in hospital or institution? 4 yrs., 1 mo., 27 days.

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County   
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 1102 Lombard Street  
(If rural, give LOCATION)  
2.(a) If veteran, name war  ✓

### 3. (a) FULL NAME

Charles Snyder

### 3. (b) Social Security Number

4 Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced divorced

6. (b) Name of husband or wife Metalline Morton  
6. (c) If alive, give age  years

7. Birth date of deceased (mo., day, yr.) April 1, 1887

8. AGE: Years 61 Months 8 Days 24 If less than one day  hrs.  min.

9. Birthplace Baltimore  
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

12. Name William H. Snyder

13. Birthplace Baltimore

14. Maiden name Martha ?

15. Birthplace Unknown

16. Informant Hospital records

Address Catonsville-28-Maryland

17. Burial Spring Grove State Hospital

(Burial, cremation, or removal. Which?) Date thereof Jan. 4, 1949  
(month) (day) (year)

Cemetery or crematory Catonsville 28, Maryland

Location Spring Grove State Hospital

18. Funeral director Catonsville 28, Md.

Address

19. 1-# 19 48 V.E. Harry Registrar

(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH December 25 19 48 at 9:10 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 28 19 48 to Dec. 25 19 48

and that I last saw him alive on December 25 19 48

Immediate cause of death Bilateral lower lobar pneumonia; right upper lobar pneumonia DURATION 36 hrs.

~~xxx~~ Paralytic ileus; early gangrene of descending colon indef.

~~xxx~~ Partial obstruction descending colon and sigmoid due to adhesions

Other conditions and constipation. 1 week

Generalized arteriosclerosis indef.  
(Include pregnancy within 3 months of death)

Major findings of operations  Date of op.

Autopsy results As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide  Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury  Injured at work?

Isadore Tuerk, M.D.

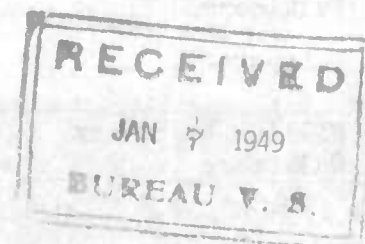
23. SIGNATURE Isadore Tuerk, M.D. M. D. or other

Address Catonsville-28-Maryland Date signed 1/3/49

MARGIN RESERVED FOR BINDING

VS A15 9.45.15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 37

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Sparks  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 30 yrs.  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Baltimore  
 City or town Sparks (Rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Quaker Bottom Rd. # 1  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

Amie Speed

## 3. (b) Social Security Number

—

4. Sex F 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Widowed  
 6. (b) Name of husband or wife James Speed  
 6. (c) If alive, give age — years  
 7. Birth date of deceased (mo., day, yr.) March 16, 1870  
 8. AGE: Years 78 Months 8 Days 24 If less than one day — hrs. — min.

9. Birthplace Virginia  
 (Town, county, and state)  
 10. Usual occupation Housewife  
 11. Industry or business  
 12. Name Harry Wilson  
 13. Birthplace Virginia  
 14. Maiden name J. Wilson  
 15. Birthplace

16. Informant Joseph Speed  
 Address Sparks, Md.  
 17. Burial Date thereof Dec. 13, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Gough's  
 Location Cuba Rd., Cockeysville, Md.  
 18. Funeral director Sander M. Brooks  
 Address Sparks, Md.

19. Dec. 11, 1948 Wilmer C. Ensor  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10 19 48 at 6<sup>30</sup> P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 10 19 48 and that I last saw her alive on Dec. 9 19 48

Immediate cause of death Cardio-Vascular renal disease

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. M. France M. D. or other

Address Parleton, Md. Date signed 12/11/48



RECEIVED

DEC 15. 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard,  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 145 daysHospital, institution, or street address where death occurred:  
VAH Fort Howard, MarylandHow long in hospital or institution? 145 days.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Kansas County \_\_\_\_\_City or town Arkansas City  
(If outside city or town limits, write RURAL and give nearest town)Street No. 220 W. Linden Street  
(If rural, give LOCATION)2. (a) If veteran, name war WW I ✓

## 3. (a) FULL NAME

NORVILLE H. STAIRS

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Deceased7. Birth date of deceased (mo., day, yr.) March 8, 1901 6. (c) If alive, give age \_\_\_\_\_ years8. AGE: Years 47 Months 9 Days 18 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Oklahoma  
(Town, county, and state)10. Usual occupation Seaman

11. Industry or business \_\_\_\_\_

12. Name Unknown13. Birthplace II14. Maiden name Unknown15. Birthplace Kansas16. Informant Clinical RecordsAddress Vets. Adm. Hosp., Fort Howard, Md.17. Removal Date thereof Dec. 28, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory \_\_\_\_\_

Location Wichita, Kansas (Downing Mortuary)18. Funeral director Howard BlightAddress 6009 Harford Rd., Baltimore, Md.19. Dec 27- 48 D. J. Harbes  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 26, 1948 at 5:45 PM21. I CERTIFY that death occurred on the date above stated: that I attended deceased from August 13, 1948 to Dec. 26, 1948 and that I last saw him alive on December 26, 1948Immediate cause of death Malignant brain tumor DURATION 7 Mos. plus

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Robert ParkerROBERT PARKER, M. D. M. D. or other \_\_\_\_\_Address VAH, Fort Howard, Md. Date signed Dec 28, 48

RECEIVED

DEC 29 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville 28, Maryland  
 (if outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 8 yrs. 1 mo. 14 das.  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution? 8 yrs. 1 mo. 14 das.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County   
 City or town Baltimore  
 (if outside city or town limits, write RURAL and give nearest town)  
 Street No. 120 S. Carroll Street  
 (if rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

Emma Stallkamp

## 3. (b) Social Security Number

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed  
 6. (b) Name of husband or wife John Stallkamp  
 7. Birth date of deceased (mo., day, yr.) August 28, 1872  
 6. (c) If alive, give age  years  
 8. AGE: Years 76 Months 3 Days 3 It less than one day hrs. min.

9. Birthplace Maryland  
 (Town, county, and state)  
 10. Usual occupation None  
 11. Industry or business None  
 12. Name John Cooksey  
 13. Birthplace Maryland  
 14. Maiden name Sophie Ridder  
 15. Birthplace Germany

16. Informant Hospital Record  
 Address Catonsville 28, Maryland  
 17. Burial Date thereof Dec 3/48  
 (Burial, cremation, or reinterment) (month) (day) (year)  
 Cemetery or crematory Philippine Cemetery  
 Location 2024 Calverton Rd  
 18. Funeral director   
 Address   
 19. 12/2/48 Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 1, 1948 at 5:45 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
October 17, 1948 to December 1, 1948  
 and that I last saw her or alive on December 1, 1948

Immediate cause of death Terminal broncho pneumonia DURATION 24 hours

Due to Arteriosclerotic heart disease indefinite

Due to Arteriosclerosis, generalized "

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results none Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide  Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury  Injured at work?

23. SIGNATURE Isadore Tuerk, M.D. M. D. or other

Address Catonsville 28, Md. Date signed 12/1/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

12275

Reg. Dist. No. 38

## 1. PLACE OF DEATH

County BaltimoreCity or town Towson  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 months

Hospital, institution, or street address where death occurred:

19 W. Penna. Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Virginia CountyCity or town Richmond  
(If outside city or town limits, write RURAL and give nearest town)Street No. 4306 Cary St. Road  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Helen Cecil Stanford

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widowed

## 6. (b) Name of husband or wife

Thomas Alexander Stanford

## 7. Birth date of deceased (mo., day, yr.)

Sept. 16, 1880

## 6. (c) If alive, give age years

## 8. AGE:

Years

Months

Days

If less than one day

6837

hrs.

min.

## 9. Birthplace

Bedford, Va.  
(Town, county, and state)

## 10. Usual occupation

Housewife

## 11. Industry or business

Own home

## FATHER

## 12. Name

William R. Cecil

## 13. Birthplace

Bedford Va.

## MOTHER

## 14. Maiden name

Frances Terry (Frances Terry)

## 15. Birthplace

Bedford, Virginia

## 16. Informant

Cecil Stanford (daughter)

## Address

Monkton, Md.17. Cremation

(Burial, cremation, or removal. Which?)

Date thereon Dec. 24, 1948  
(month) (day) (year)

## Cemetery or crematory

Greenmount Crematory

## Location

Greenmount Ave., Balto., Md.

## 18. Funeral director

John Beebe's Sons

## Address

Towson, Md.19. Dec. 24, 1948

(Date rec'd by registrar)

R. W. Belbricker  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 23, 1948 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to..... 19.....

and that I last saw him alive on..... 19.....

Immediate cause of death Heart disease, coronarywith occlusion - sudden

## DURATION

Sudden

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, pub'c place (where?)

Means of injury Injured at work?

23. SIGNATURE

Rollin C. Hudson M.D. D.M.E.  
M. D. or other  
Address Towson Md. Date signed 12/23/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

12276

43

## 1. PLACE OF DEATH:

County BaltimoreCity or town Fullerton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MdCounty BaltimoreCity or town Fullerton

(If outside city or town limits, write RURAL and give nearest town)

Street No. 7731 Belair Road

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

JOSEF STASTNY

## 3. (b) Social Security Number

None

4 Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widow

6.(b) Name of husband or wife

Katerina

7. Birth date of deceased (mo., day, yr.)

April 6, 1856

6.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

92728

hrs.

min.

9. Birthplace

Bohemia, Austria

(Town, county, and state)

10. Usual occupation

Agent retired

11. Industry or business

Md Bible Society

MOTHER FATHER

12. Name

Josef Stastny

13. Birthplace

Bohemia, Austria

14. Maiden name

(Unknown) Zelanka

15. Birthplace

Bohemia, Austria

16. Informant

Helen S. Manzke

Address

7731 Belair Road.

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof

12/7/48

(month) (day) (year)

Cemetery or crematory

Oak Hill

Location

Baltimore, Md.

18. Funeral director

William Cook, Inc

Address

1217 St. Paul

19.

Dec 6 19 48

19

48

a. w. H. H. H.

a. w. H. H. H.

a. w. H. H. H.

a. w. H. H. H.

a. w. H. H. H.

a. w. H. H. H.

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a. w. H. H. H.

a. w. H. H. H.

a. w. H. H. H.

a. w. H. H. H.

23. SIGNATURE

Walter A. Anderson

M. D. or other

Address

3001 Shannon Drive

Date signed

12-6-48

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec 5, 1948

19

at

3:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 15

19

48

to

Dec 5

19

48

and that I last saw him alive on

Dec 4

19

48

Immediate cause of death

Coronary occlusion

DURATION

Due to

arteriosclerosis

Due to

chronic nephritis

Other conditions

anemia, senility

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH 93d

Reg. Dist. No. 42

## 1. PLACE OF DEATH:

County... Baltimore 29City or town... Ridgewood  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infant, give residence of mother)

State... Maryland County... BaltimoreCity or town... Ridgewood  
(If outside city or town limits, write RURAL and give nearest town)Street No... 4408 Highview Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Ernest W. Stevenson

## 3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife

Margaret J. Stevenson  
ne Taylor

7. Birth date of deceased (mo., day, yr.)

June 6 - 1869

6.(c) If alive, give age... years

8. AGE:

Years

Months

Days

If less than one day

796

hrs.

min.

9. Birthplace... Virginia  
(Town, county, and state)10. Usual occupation... Retired

11. Industry or business

12. Name... William W. Stevenson13. Birthplace... Maryland14. Maiden name... Sarah Hall15. Birthplace... Virginia16. Informant... Mrs. Margaret J. StevensonAddress 4408 Highview Ave17. Burial Date thereof 12/8/48  
(Burial, cremation, or removal, which?) (month) (day) (year)Cemetery or crematory... Green Lawn Cemetery

Location

18. Funeral director... Charles P. TowellAddress 2427 Edmondson Ave19. Dec 7 19 48 A. W. Hedrick  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... Dec 6 1948 at 3:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 1 1948 to Dec 6 1948and that I last saw him alive on Dec 5 1948

Immediate cause of death

Cerebral Thrombosis

DURATION

5 daysDue to Arteriosclerotic Cerebro-vascular Disease

Due to

Other conditions Similarity

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address... 400 N. Payson St Date signed 12/6/48

Dr McLaughlin  
400 N Payson St.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 42

## 1. PLACE OF DEATH:

County... Baltimore  
 City or town... Halethorpe  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

JAMES STEWART

## 3. (b) Social Security Number

215-09-9599

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Elma E. Stewart

7. Birth date of deceased (mo., day, yr.)

Jan. 24 th. 1882

6. (c) If alive, give age

58

8. AGE:

Years  
66Months  
10Days  
25

If less than one day

.....hrs. ....min.

9. Birthplace

Ireland

(Town, county, and state)

10. Usual occupation

Butcher

11. Industry or business

Hill Company

FATHER  
MOTHER

12. Name

William Stewart Sr.

13. Birthplace

Ireland

14. Maiden name

Eliza Dilworth

15. Birthplace

Ireland

16. Informant

Elma E. Stewart (Wife)

Address

5558 Link Ave. Halethorpe

17.

Burial

Date thereof Dec. 22/1948  
(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Loudon Park Cemetery

Location

Baltimore Maryland

18. Funeral director

F. B. WIPPERT &amp; SON

Address

1300 EUTAW PLACE... 17

19.

(Date rec'd by registrar)

19.

48

Gert Kieffer

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... BaltimoreCity or town... Halethorpe  
(If outside city or town limits, write RURAL and give nearest town)Street No... 5558 Link Ave.  
(If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH... December 19 th. 48 at 5:10 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 48 to Nov 19 19 48  
and that I last saw him alive on Nov 19 19 48

Immediate cause of death

DURATION

Acute cardiac failure sudden

Due to

Due to Cardiovascular disease  
Coronary

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury

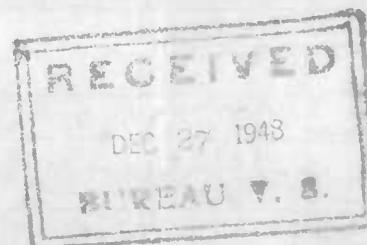
Injured at work?

23. SIGNATURE

Geo. M. Kieffer

M. D. or other

Address 1010 Leach StDate signed 12-21-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 175C 122367

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Ellicott City Westchester Ave  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 hours  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Baltimore  
 City or town Ellicott City  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Hollow Road and Westchester Ave  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war. None

## 3. (a) FULL NAME

Harry Vernon Stokes  
 4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Grace Brown Stokes  
 6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) March 3 1878

8. AGE: Years 70 Months 9 Days 6 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Virginia  
 (Town, county, and state)

10. Usual occupation General Utility Work

11. Industry or business

MOTHER FATHER  
 12. Name Unknown  
 13. Birthplace "  
 14. Maiden name "  
 15. Birthplace "

16. Informant Mrs. Grace V. Stokes  
 Address Ellicott City, Md.

17. Burial Burial Date thereof 12-11-1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory St. Johns  
 Location Ellicott City Md

18. Funeral director F. C. Higinbotham  
 Address Ellicott City, Md.

19. 12-10-48 J. E. Harry  
 (Date rec'd by registrar) Registrar

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 9th 48 10-20a

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_  
 and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_

Immediate cause of death fracture of skull  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions Accident  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_  
 Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Accident Date of Dec 9, 48  
 Where did injury occur? Calinsville Bald Md  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Indus  
hit by falling tree limb  
 Means of injury while cutting trees Injured at work? yes

23. SIGNATURE J. E. Harry Kept filed  
 Address 1010 Tuck on M. D. or other Kept filed  
 Date signed Dec 9-48

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

RECEIVED  
DEC 11 1948  
BUREAU 7. 8.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Arbutus Oakton  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 20 yrs  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Md County Baltimore  
 City or town Arbutus Oakton  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1008 Leeds Ave  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Lydia Emmett Tall

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed  
 6. (b) Name of husband or wife John L. Tall  
 7. Birth date of deceased (mo., day, yr.) Feb 22 - 1858 6. (c) If alive, give age years  
 8. AGE: Years 90 Months 10 Days 9 If less than one day hrs. min.

9. Birthplace Dorchester Co Md  
 (Town, county, and state)  
 10. Usual occupation House wife  
 11. Industry or business at home  
 12. Name Richard Swindell  
 13. Birthplace Camden N. J.  
 14. Maiden name Charlotte Threnditoff  
 15. Birthplace Penna

16. Informant John H. Guffey  
 Address Cpt 157 Oakden Village  
Burial Date thereof Jan 3 - 49  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Loudon Park  
 Location Friederick Ave

18. Funeral director E. W. Lamoreau  
 Address 4370 Liberty Hts Ave  
 19. Jan 49  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 31 1948 at 4 P  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 48 1948 to Dec 31 1948  
 and that I last saw him alive on Dec 31 1948

Immediate cause of death Acute Cardiac failure  
 Due to Cardio Vascular disease  
 Other conditions Semiplegia  
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....  
 Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?  
 23. SIGNATURE G. M. Kieffer M. D. Author  
 Address 1010 Leeds Ave Date signed Jan 1. 49

RECEIVED

JAN 3 1949

BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

12281

Reg. Dist. No. 4X

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Fort Howard  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 51 days  
 Hospital, institution, or street address where death occurred:  
Vet. Adm. Hosp., Fort Howard, Maryland  
 How long in hospital or institution? 51 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County \_\_\_\_\_  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 213 W. Mosher Street  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war WW II

## 3. (a) FULL NAME

NATHANIEL BANKS TUCKER

## 3. (b) Social Security Number

Unknown

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Mrs. Jean Tucker  
 6. (c) If alive, give age 28 years  
 7. Birth date of deceased (mo., day, yr.) April 15, 1907  
 8. AGE: Years 41 Months 8 Days 15 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Baltimore, Maryland  
 (Town, county, and state)  
 10. Usual occupation Tavern Keeper  
 11. Industry or business \_\_\_\_\_  
 12. Name Samuel Tucker  
 13. Birthplace Russia  
 14. Maiden name Anna Mendelson  
 15. Birthplace Russia

16. Informant Clinical Records, Vet. Adm. Hosp.  
 Address Fort Howard, Maryland  
 17. Burial Dec 31/48  
 (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)  
 Cemetery or crematorium Hebron Washington Road Cemetery  
 Location Washington Blvd  
 18. Funeral director Sol Levinson & Bros.  
 Address 1126 W. North Ave., Baltimore, Md.

19. 12/30 19 48 A.W. Hedrick  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 30 19 48 at 5:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 9 19 48 to December 30 19 48 and that I last saw him alive on December 30 19 48

Immediate cause of death EMBOLISM, PULMONARY  
 DURATION Instantaneous

Due to Infarction of myocardium, due to arteriosclerotic coronary artery thrombosis, recurrent  
5 years

Other conditions \_\_\_\_\_  
 (Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results None  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE H.C. Manauh  
H.C. MANAUGH, M.D., CHIEF PRO. SERVICES  
 Address V.A.H., FORT HOWARD, MD. Date signed 12-30-48

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

12282

30

### 1. PLACE OF DEATH:

County Baltimore  
City or town Catonville  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 4 days  
Hospital, institution, or street address where death occurred:  
Spring Grove Hospital  
How long in hospital or institution? 4 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Baltimore  
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 2728 Mosher St.  
(If rural, give LOCATION)  
2.(a) If veteran, name war ✓

### 3. (a) FULL NAME

BERNARD LEROY TULLY

### 3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Separated

### 8.(b) Name of husband or wife

Dorothy

7. Birth date of deceased (mo., day, yr.) June 14, 1901

6.(c) If alive, give age 42 years

8. AGE: Years 47 Months 5 Days hrs. min.

9. Birthplace Baltimore, Md.  
(Town, county, and state)

10. Usual occupation Salesman

### 11. Industry or business

12. Name Francis J. Tully

13. Birthplace Baltimore

14. Maiden name Mary J. Tully

15. Birthplace Baltimore

16. Informant Mrs. Joseph Smith

Address 2728 N. Mosher St.

17. Cause suicide Date thereof 12/3/48  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Cathedral

Location old Frederick Road

18. Funeral director J. J. Fahy & Sons

Address 1318 Light St.

19. Dec 6 48 R. W. Hedrick  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 12/3 19 48, at 7 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/30 19 48 to 12/3 19 48  
and that I last saw him alive on 12/3 19 48

Immediate cause of death Cardiac failure DURATION 1 day

Due to cardiac enlargement + decompensation

Due to Chronic cardiac vascular disease several  
years

Other conditions Chronic alcoholism

(Include pregnancy within 3 months of death)

Major findings of operations not done

Date of op. not done

Autopsy results not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of 12/3/48

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, pub'c place (where?)

Means of injury Gunshot Injured at work?

23. SIGNATURE R. W. Hedrick M. D. or other

Address Spring Grove Hosp. Date signed 12/3/48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

50

12283

Reg. Dist. No. 41

## 1. PLACE OF DEATH:

County BaltimoreCity or town Bundalk  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Balto.City or town Bundalk  
(If outside city or town limits, write RURAL and give nearest town)Street No. 6521 Fair Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Margaret Walsh

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Charles Walsh

## 7. Birth date of deceased (mo., day, yr.)

Dec. 10, 1880

## 6. (c) If alive, give age

66 years

## 8. AGE:

68

Years

Months

8

Days

If less than one day

hrs.

min.

## 9. Birthplace

Md.

(Town, county, and state)

## 10. Usual occupation

None

## 11. Industry or business

None

## FATHER

## 12. Name

Streh

## 13. Birthplace

Unknown

## MOTHER

## 14. Maiden name

Unknown

## 15. Birthplace

Unknown

## 16. Informant

Mrs Charles Walsh

## Address

6521 Fair Ave

## 17. BURIAL

(Burial, cremation, or removal. Which?)

## Date thereof

12/22/48  
(month) (day) (year)

## Cemetery or crematory

LOUDON PARK

## Location

FREDERICK RD.

## 18. Funeral director

JOHN F DENNY, INC.

## Address

715 LIGHT ST -3019. Dec 21

(Date rec'd by registrar)

48A. W. Hedrick

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 18 19 48 at 9 15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 2219 47to Dec 1819 48and that I last saw h alive on Dec 16 19 48

Immediate cause of death

Carcinomatosis

## DURATION

2 months

Due to

Carcinoma left breast5 years

Due to

Rheumatic valvular heart disease2 years

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

David H. Andrew M.D.

M. D. or other

Address 2 Kingsley Rd Bundalk Md Date signed 12/18/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hospital, Ft. Howard, Md.How long in hospital or institution? 2 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1128 Druid Hill Avenue  
(If rural, give LOCATION)2. (a) If veteran, name war WW-I ✓

## 3. (a) FULL NAME

CHARLES H. WATTS

## 3. (b) Social Security Number

Unknown

## 4. Sex

Male

## 5. Color or race

Colored

## 6. (a) Single, married, widowed, or divorced

## 8. (b) Name of husband or wife

Lucinda WattsB. (c) If alive, give age 38 years

## 7. Birth date of

deceased (mo., day, yr.)

7-23-90

## 8. AGE:

Years

58

Months

4

Days

9

If less than one day

hrs.

min.

## 9. Birthplace

Baltimore, Md.

(Town, county, and state)

## 10. Usual occupation

Unemployed

## 11. Industry or business

## MOTHER FATHER

## 12. Name

Arthur Watts

## 13. Birthplace

Virginia

## 14. Maiden name

Queenann Holmes

## 15. Birthplace

Essex County, Va.

## 16. Informant

Clinical Records, Vets. Adm. Hosp.

## Address

Fort Howard, Maryland

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 12/1/48  
(month) (day) (year)Cemetery or crematory Baltimore National CemeteryLocation Baltimore, Md.

## 18. Funeral director

Charles R. LawAddress 802 Madison Ave. Balto. Md.

## 19.

(Date rec'd by registrar)

Dec. 3, 48

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 2, 1948 at 2:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

November 30, 1948 to December 2, 1948and that I last saw him alive on December 2, 1948

Immediate cause of death

MILITARY TUBERCULOSIS

DURATION

Unknown

Due to

Due to

Other conditions None

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

H.C. MANAUGH, M.D., CHIEF, PROFESSOR OF PATHOLOGYAddress VAH Ft. Howard, Md.Date signed 12/3/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. 12285

<b>1. PLACE OF DEATH:</b> County..... <u>Baltimore,</u> City or town..... <u>Woodlawn</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... <u>67 yrs. in Maryland</u> Hospital, institution, or street address where death occurred: _____ How long in hospital or institution?.....				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State..... <u>Maryland</u> County..... <u>Baltimore</u> City or town..... <u>Woodlawn</u> (If outside city or town limits, write RURAL and give nearest town) Street No..... <u>3479 Meadowside Ave.</u> (If rural, give LOCATION) 2.(a) If veteran, name war.....			
<b>3. (a) FULL NAME</b> <u>Helen Wegeng</u>				<b>3. (b) Social Security Number</b> --			
<b>4. Sex</b> <u>female</u>		<b>5. Color or race</b> <u>white</u>		<b>6. (a) Single, married, widowed, or divorced</b> <u>Widow</u>		<b>MEDICAL CERTIFICATION</b>	
<b>6. (b) Name of husband or wife</b> <u>August Wegeng</u>				<b>20. DATE OF DEATH</b> <u>December 13,</u> 19 <u>48</u> at <u>11</u> P.			
<b>7. Birth date of deceased (mo., day, yr.)</b> <u>August 8, 1857</u>				<b>21. I CERTIFY that death occurred on the date above stated; that I attended deceased from</b> <u>Jan</u> 19 <u>38</u> to <u>12/13 - 1948</u> and that I last saw her alive on <u>12/13 - 1948</u>			
<b>8. AGE:</b> Years <u>91</u>		Months <u>4</u>		Days <u>5</u>		If less than one day .... hrs. .... min.	
<b>9. Birthplace</b> <u>Germany</u> (Town, county, and state)				<b>Immediate cause of death</b> <u>Arteriosclerosis</u>			
<b>10. Usual occupation</b> <u>Housewife,</u>				Due to.....			
<b>11. Industry or business</b> <u>at home</u>				Due to.....			
<b>12. Name</b> <u>Joseph Pranke,</u>				Other conditions.....			
<b>13. Birthplace</b> <u>Germany,</u>				(Include pregnancy within 3 months of death)			
<b>14. Maiden name</b> <u>unknown,</u>				<b>Major findings of operations</b> ..... Date of op. ....			
<b>15. Birthplace</b> <u>Germany.</u>				<b>Autopsy results</b> <b>PHYSICIAN: Please underline the cause to which death should be charged statistically.</b>			
<b>16. Informant</b> <u>Miss Margaret Wegeng,</u> Address <u>3479 Meadowside Ave.</u>				<b>22. VIOLENCE: If death was due to external causes, fill in the following:</b> Accident, suicide, or homicide..... Date of..... Where did injury occur?..... (City or town) (County) (State) Injured at home, farm, industry, public place (where?)..... Means of injury..... Injured at work?.....			
<b>17. Burial</b> (Burial, cremation, or removal. Which?) Date thereof <u>12/16/48</u> (month) (day) (year) Cemetery or crematory..... <u>Woodlawn,</u> Location <u>Woodlawn, Balto. Co., Md.</u>				<b>23. SIGNATURE</b> <u>Eugene Zeller, M.D.</u> Address <u>2739 Eastern Ave.</u> Date signed <u>12/15/48</u>			
<b>18. Funeral director</b> <u>Vernon Lemmon</u> Address <u>4611 Park Heights Ave., Balto. Md.</u>				<b>19.</b> <u>12/15</u> 19 <u>48</u> <u>A. W. Hedrick</u> (Date rec'd by registrar) Registrar			

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information fully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. 30

## 1. PLACE OF DEATH:

County..... Baltimore  
 City or town..... Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 12 years, 6 months, 2 days  
 Hospital, institution, or street address where death occurred:  
 Spring Grove State Hospital  
 How long in hospital or institution 12 years, 6 months, 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... Maryland County.....  
 City or town..... Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 412 East Lafayette Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... ✓

## 3. (a) FULL NAME

(Frances)

Ella F. Weinerich

## 3. (b) Social Security Number

none

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widowed

## 6. (b) Name of husband or wife

Charles Weinerich

## 7. Birth date of deceased (mo., day, yr.)

March 19, 1862

## 6. (c) If alive, give age..... years

## 8. AGE:

Years 86

## Months

9

## Days

7

## If less than one day

..... hrs. .... min.

## 9. Birthplace

Balto., Maryland

(Town, county, and state)

## 10. Usual occupation

Housewife

## 11. Industry or business

Home

## MOTHER FATHER

## 12. Name

William W. Wharton

## 13. Birthplace

Balto. Maryland

## 14. Maiden name

Mary Jane Craig

## 15. Birthplace

Balto. Maryland

## 16. Informant

Hospital records

Address Catonsville, 28, Maryland

## 17.

Burial

## Date thereof

12/28/48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

## Cemetery or crematory

Greenmount Cem.

## Location

Balto., Md.

## 18. Funeral director

WM. J. TICKNER &amp; SONS

## Address

Balto., Md.

## 19.

12/27

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## MEDICAL CERTIFICATION

20. DATE OF DEATH December 26, 1948 at 11 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 24, 1936

19

to

December 26

19

48

and that I last saw h. ex. alive on December 26 19 48

Immediate cause of death

Pyæmia - undiagnosed

DURATION

18 days

Due to

Arteriosclerotic kidney disease - Indef

Due to

Arteriosclerotic heart disease

Due to

Generalized arteriosclerosis

Other conditions

Hypertensive C-V disease

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

None held

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Henry C. A. Mead, M. D. M. D. or other

Address Catonsville, 28, Md.

Date signed 12/26/48

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 12287 38

### 1. PLACE OF DEATH:

County Baltimore Co. Md.

City or town Towson  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Sudden

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore

City or town Lutherville  
(If outside city or town limits, write RURAL and give nearest town)

Street No. Bellona Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war World War I

### 3. (a) FULL NAME

Clarence D. Steet

### 3. (b) Social Security Number

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife:

7. Birth date of deceased (mo., day, yr.) April 8, 1901

8. AGE: Years 47 Months 9 Days 26 If less than one day hrs. min.

9. Birthplace Middlebury Co. Va.  
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Monument & Marble work.

12. Name Louis Steet

13. Birthplace Virginia

14. Maiden name Unknown

15. Birthplace Virginia

16. Informant Mrs. Lillian Steet

Address 632 George St. Baltimore

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof Dec. 8, 1948  
(month) (day) (year)

Cemetery or crematory Baltimore Nat'l.

Location Baltimore, Md.

18. Funeral director Mrs. George W. Hall

Address 1631 Druid Hill Ave.

19. 12/8/48 Registrar

(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 3, 1948 at 11:40 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

end that I last saw h. None 19. to 19.

Immediate cause of death Infarction in myocardium

Due to Mother's fracture, over exertion

Due to and contusions

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Auto Date of 12/3/48

Where did injury occur? Towson (City or town) Essex (County) Md. (State)

Injured at home, farm, industry, public place (where)? Public Highway U.S. 41

Means of injury Struck by auto Injured at work? No

23. SIGNATURE Robert P. Huber M.D. D.M.E.

Address Towson Md. Date signed 12/4/48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

12288

38

## Cromwell CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH: Cromwell Bridge Rd.  
County: Baltimore County

City or town: (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State: Mass. County: Cecily

City or town: Dedham Mass  
(If outside city or town limits, write RURAL and give nearest town)Street No.: 70 Oakdale Road  
(If rural, give LOCATION)

2.(a) if veteran, name war:

3. (a) FULL NAME

Boyd, Whitting.

3. (b) Social Security Number

4. Sex: M. 5. Color or race: W. 6. (a) Single, married, widowed, or divorced: single

6. (b) Name of husband or wife:

7. Birth date of deceased (mo., day, yr.): Feb. 19, 1889

8. AGE: Years: 59 Months: 9 Days: 15 If less than one day: hr. min.

9. Birthplace: Dedham, Mass.  
(Town, county, and state)

10. Usual occupation: Transportation Manager.

11. Industry or business: Metropolitan Transportation Authority

12. Name: James C. Whitting

13. Birthplace: Dedham, Mass.

14. Maiden name: Emily Fuller

15. Birthplace: Groton, Mass

16. Informant: Mr. John B. Hiss

Address: Cromwell Bridge Rd - Ind.

17. Removal: Date thereof: 12-5-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Brookdale

Location: Dedham, Mass.

18. Funeral director: Wm J. Fickner + Sons

Address: North and Pa. Aves - Balt. Md

19. Dec 10 1948

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH: December 4, 1948, at 9:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 2, 1947, to Dec 4, 1948 and that I last saw him alive on Dec 4, 1948.

Immediate cause of death: Coronary Thrombosis. DURATION: 45 min.

Died from: Coronary Sclerosis. Indefinite

Died from: Myocarditis. Indefinite

Other conditions: (Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury: Injured at work?

23. SIGNATURE: Notarized by Beck, MD

Address: 100 E. 23rd St. Baltimore signed Dec 5, 1948

RECEIVED

JAN 3 1949

BUREAU V. S.

RECEIVED

JAN 3 194.

BUREAU V. S.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

12289

Reg. Dist. No. 30

### 1. PLACE OF DEATH:

County Baltimore  
City or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 37 years, 9 months  
Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
How long in hospital or institution? 37 years, 9 months

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Charles  
City or town Issue  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. ?  
(If rural, give LOCATION)  
2(a) If veteran, name war ✓

### 3. (a) FULL NAME

William T. Wills

### 3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced single  
6. (b) Name of husband or wife -  
6. (c) If alive, give age - years  
7. Birth date of deceased (mo., day, yr.) 1860?  
8. AGE: Years 88 Months ? Days ? If less than one day - hrs. - min.

9. Birthplace Maryland  
(Town, county, and state)  
10. Usual occupation Oysterman  
11. Industry or business Oyster  
MOTHER FATHER  
12. Name ? Wills  
13. Birthplace ?  
14. Maiden name ?  
15. Birthplace ?

16. Informant Hospital records  
Address Catonsville-28, Maryland  
17. BURIAL Date thereof DEC. 3 '48  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory NEW CATHEDRAL  
Location OLD FREDERICK RD  
18. Funeral director Sam H. Witke  
Address 4101 Elmwood Ave  
19. 12-2-48 19. VE. Harry  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH December 1 19 48 at 4:25 pm  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 19 11 to December 1 19 48  
and that I last saw him alive on December 1 19 48  
Immediate cause of death Cerebral vascular accident DURATION 9 days  
Due to Hypertensive cardiovascular disease with arteriosclerosis, generalized indefinite  
Other conditions Ectropion palpebrae  
(Include pregnancy within 3 months of death)

Major findings of operations - Date of op. -  
Autopsy results none  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide - Date of -  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?) -  
Means of injury - Injured at work? -  
23. SIGNATURE Isadore Tuerk, M.D. M. D. or other  
Address Catonsville-28, Md. Date signed 12-2-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

DEC 6 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

12290

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Fort Howard, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 121 days  
 Hospital, institution, or street address where death occurred:  
Vets. Adm. Hosp. Fort Howard, Md.  
 How long in hospital or institution? 121 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Balt  
 City or town Glen Arm  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Hines Road  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war WW-2

## 3. (a) FULL NAME

EDMUND E. WIRTH

## 3. (b) Social Security Number

Unknown

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Hilda Wirth  
 6. (c) If alive, give age 28 years

7. Birth date of deceased (mo., day, yr.) July 2, 1918  
 8. AGE: Years 30 Months 5 Days 16 If less than one day  
 ..hre. ....min.

9. Birthplace Baltimore, Maryland  
 (Town, county, and state)  
 10. Usual occupation Carpenter's Helper

11. Industry or business

12. Name Henry Wirth  
 13. Birthplace Pa.

14. Maiden name Cora Work  
 15. Birthplace Pa.

16. Informant Clinical Records, Vets. Adm. Hosp.  
 Address Fort Howard, Maryland

17. Burial Date thereof (month) (day) (year)  
 (Burial, cremation, or removal. Which?)  
 Cemetery or crematory Moreland Memorial Park Cemetery  
 Location 5806 Harford Rd. Balto. Md.

18. Funeral director Lassahn Funeral Home  
 Address 7401 Belair Rd. Balto. Md.

19. Dec 20 19 48 A.W. Hadwick  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 18 19 48 at 6:45A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
June 14 19 48 to Dec. 18 19 48  
 and that I last saw him alive on December 18 19 48

Immediate cause of death  
Granulomatous cerebro-spinal  
meningitis

## DURATION

6 mos.Due to unknown

Due to

Other conditions none

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results substantiated above  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE William Heath M. D. or otherAddress VAH FT. Howard, Md. Date signed 12-18-48

BALTIMORE CITY HEALTH DEPARTMENT  
 CERTIFICATE OF DEATH

Registered No. 131a

1. PLACE OF DEATH: County

(a) Baltimore ~~City~~ Maryland

(b) Street address 4216 Kensington Rd

(c) ~~Hospital or institution:~~

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 9 yrs 6 mos

2. USUAL RESIDENCE OF DECEASED:

(a) State Md.

(b) County Baltimore Co.

(c) City or town Kensington  
 (If outside city or town limits, write RURAL and give town)

(d) Street No. 4216 Kensington Rd.

(If rural give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country

3 (a) FULL NAME Bessie Wiseman

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

Female

White

Widowed

6 (b) Name of husband or wife Edward Wiseman

(deceased)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-9-1893

8. AGE:

Years

Months

Days

If less than one day

76

hr.

min.

9. Birthplace Baltimore Md

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

12. Name William Johnson

13. Birthplace Maryland

14. Maiden Name Katherine Holman

15. Birthplace Maryland

16 (a) Informant

(b) Address 4216 Kensington Rd

17 (a) Burial

(b) Date thereof Dec 27-48

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Western

Location Baltimore Md

18 (a) Funeral director J. B. Wappert & Son

(b) Address 1000 Eutaw Place

19 (a)

12/27 (b) 48 A.W. Nelson

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 23, 1948, at 7:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1948 to Dec 23 1948, and that I last saw him alive on Dec. 22, 1948.

Immediate cause of death

Coronary occlusion

Duration

1 hour

Due to

Myocarditis

1 yr.

Due to

Chronic nephritis (arterio-sclerotic type)

Under

Other Conditions

Aortic sclerosis and advanced age  
 (Include pregnancy within 3 months of death)

PHYSICIAN

Date of operation

Major findings of operation:

Underline the cause to which death should be charged statistically.

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Barbara Gaggott M. D.

Address 3812 Greenmount Ave

Dec. 23 '48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 12292

## 1. PLACE OF DEATH

County BaltimoreCity or town Edgemere  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 28 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County BaltCity or town Edgemere  
(If outside city or town limits, write RURAL and give nearest town)Street No. 2538 Sycamore Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Malinda Yarbrough

## 3. (b) Social Security Number

4. Sex

F

5. Color or race

C

6. (a) Single, married, widowed, or divorced

W6. (b) Name of husband or wife Luther Yarbrough

7. Birth date of

deceased (mo., day, yr.)

Jan. 5, 1886

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

6215

hrs.

min.

9. Birthplace Fluvanna Va.

(Town, county, and state)

10. Usual occupation

Domestic

11. Industry or business

FATHER

12. Name

James Mallory

13. Birthplace

Va.

MOTHER

14. Maiden name

Malinda Toney

15. Birthplace

Va.

18. Informant

Gutierrez Beth

Address

2538 Sycamore Ave

17.

(Burial, cremation, or removal. Which?)

Date thereof

12-13-48  
(month) (day) (year)

Cemetery or crematory

Mt. Calvary

Location

B.A. Co.

18. Funeral director

Samuel W. Sullivan

Address

1011 N. Arlington Ave

19.

(Date rec'd by registrar)

19

Registrar

23. SIGNATURE

Address

Dr. Thomas M.D.  
Turner's Sta. Md.  
12/13/48

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-10-1948 at 12:45 P.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10thMay 1948 to December 9th 1948and that I last saw her alive on December 9th 1948

Immediate cause of death

Cerebral apoplexy

DURATION

about 7 mo

Due to

Due to

Other conditions

arterio sclerosisunknown

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

M. D. or other

Date signed 12/13/48